



This is a digital copy of a book that was preserved for generations on library shelves before it was carefully scanned by Google as part of a project to make the world's books discoverable online.

It has survived long enough for the copyright to expire and the book to enter the public domain. A public domain book is one that was never subject to copyright or whose legal copyright term has expired. Whether a book is in the public domain may vary country to country. Public domain books are our gateways to the past, representing a wealth of history, culture and knowledge that's often difficult to discover.

Marks, notations and other marginalia present in the original volume will appear in this file - a reminder of this book's long journey from the publisher to a library and finally to you.

Usage guidelines

Google is proud to partner with libraries to digitize public domain materials and make them widely accessible. Public domain books belong to the public and we are merely their custodians. Nevertheless, this work is expensive, so in order to keep providing this resource, we have taken steps to prevent abuse by commercial parties, including placing technical restrictions on automated querying.

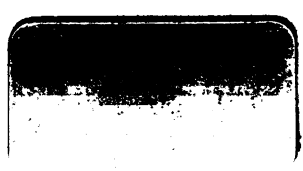
We also ask that you:

- + *Make non-commercial use of the files* We designed Google Book Search for use by individuals, and we request that you use these files for personal, non-commercial purposes.
- + *Refrain from automated querying* Do not send automated queries of any sort to Google's system: If you are conducting research on machine translation, optical character recognition or other areas where access to a large amount of text is helpful, please contact us. We encourage the use of public domain materials for these purposes and may be able to help.
- + *Maintain attribution* The Google "watermark" you see on each file is essential for informing people about this project and helping them find additional materials through Google Book Search. Please do not remove it.
- + *Keep it legal* Whatever your use, remember that you are responsible for ensuring that what you are doing is legal. Do not assume that just because we believe a book is in the public domain for users in the United States, that the work is also in the public domain for users in other countries. Whether a book is still in copyright varies from country to country, and we can't offer guidance on whether any specific use of any specific book is allowed. Please do not assume that a book's appearance in Google Book Search means it can be used in any manner anywhere in the world. Copyright infringement liability can be quite severe.

About Google Book Search

Google's mission is to organize the world's information and to make it universally accessible and useful. Google Book Search helps readers discover the world's books while helping authors and publishers reach new audiences. You can search through the full text of this book on the web at <http://books.google.com/>

Handwritten signature or initials in the top left corner.



PROCEEDINGS
OF THE
MASSACHUSETTS
Homœopathic Medical Society.

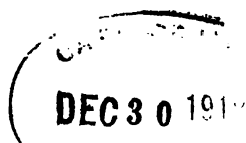
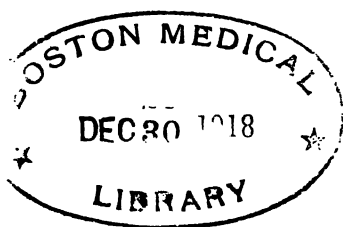
1899.

VOLUME XIII.

PUBLISHED BY THE COMMITTEE ON PUBLICATION.



BOSTON :
DANIEL GUNN & CO.,
31 Hawley Street.
1900.



ME

OFFICERS FOR 1899-1900.

EXECUTIVE COMMITTEE.

PRESIDENT.

FRANK C. RICHARDSON, M. D., Boston.

VICE-PRESIDENTS.

JOHN PRENTICE RAND, M. D., Monson.

JOHN LAMBERT COFFIN, M. D., Boston.

CORRESPONDING SECRETARY.

FREDERICK P. BATCHELDER, M. D., Boston.

RECORDING SECRETARY.

FREDERICK L. EMERSON, M. D., Dorchester.

TREASURER.

WINSLOW B. FRENCH, M. D., Boston.

LIBRARIAN.

J. WILKINSON CLAPP, M. D., Brookline.

CENSORS.

HERBERT C. CLAPP, M. D., Boston.

EDWARD P. COLBY, M. D., Boston.

HOWARD P. BELLOWS, M. D., Boston.

HORACE PACKARD, M. D., Boston.

FREDERICK B. PERCY, M. D., Brookline.

DEC 30 1891
LIBRARY

BY-LAWS

OF THE

MASSACHUSETTS

HOMŒOPATHIC MEDICAL SOCIETY,

AS IN FORCE, OCTOBER, 1899.

OBJECTS OF THE SOCIETY.

ARTICLE I. Since Homœopathy aims at the improvement and reformation of the art of healing by aid of medicines, proved by every means that promises to enlarge the knowledge of the laws governing the action of drugs, this Society hereby declares its objects to be,—

The development of the materia medica by proving drugs upon the systems of men and animals; the administering of medicines thus proved, to the sick, in accordance with the formula *similia similibus curantur*; the encouragement of special studies and reports calculated to improve its members in the collateral branches of medicine.

ART. II. This Society demands for itself absolute liberty in science, and hence requires of its applicants for membership no creed or confession of medical belief, but only the expression of a willingness to act for the furtherance of its declared objects.

SOCIETY.

ART. III. This Society shall consist of the persons named in the Act of Incorporation, and such other persons as may have been elected members in accordance with its By-Laws.

OFFICERS OF THE SOCIETY AND THEIR ELECTION.

ART. IV. *Section 1.*—The Society at its annual meeting, shall elect by ballot a president, two vice-presidents, corresponding secretary, recording secretary, treasurer, librarian, and five censors, who shall together constitute an executive committee, to whom shall be

intrusted the general business of the Society when it is not in session; the appointment of all standing committees and such other committees as they may deem expedient; the appointment of a necrologist and auditor, and the selection of some suitable person, and substitute, to deliver an oration at the semi-annual meeting of the Society, on some subject connected with medical science. At every annual meeting they shall present a report of their proceedings during the past year. They shall have power to remit the dues of worthy members who may produce satisfactory evidence that they are unable to pay. The officers shall continue in office till the adjournment of the annual meeting next after their election, at which time the duties of the newly elected officers shall commence.

Section 2. — Voting for officers of this Society shall be exclusively by ballots cast previous to the annual meeting. To this end the executive committee shall appoint a special election committee of three, none of whom shall be regular candidates for office, whose duty shall be to receive and count the ballots cast, and declare the results to the Society. Should any of this committee be absent at the opening of the annual meeting, the presiding officer shall fill such vacancies from the members present.

Section 3. — At least sixty days before the annual meeting the secretary shall forward to all members in good standing, a preliminary notice informing them of the nominations for offices made by the nominating committee; and at a date not later than fourteen days before said meeting he shall also forward (with notice of meeting and a special addressed return envelope) the official ballot containing all nominations by the nominating committee, and those by any special caucuses which may have convened for that purpose. The names of all candidates for each office shall be arranged upon the ballot in alphabetical order and, unless otherwise designated, shall be known as presented by the nominating committee. The names of all candidates for re-election shall be marked with an asterisk (*), while those nominated by a special caucus of members and certified to by at least ten members present, shall be marked with a dagger (†). If any candidate decline his nomination previous to the printing of the ballot it shall be so designated thereon.

Section 4. — All nominations by special caucus must be in the hands of the secretary at least thirty days before the annual meeting.

Section 5. — Members shall prepare their ballots by making the sign X against the names of the candidates for whom they wish to vote. If in any instance more names are thus marked than there are officers to be elected, no name for such office shall be counted. This shall not, however, invalidate the ballot for the other officers.

Section 6. — All members desiring to vote must return their ballots in the "official return envelope" to the secretary, so that they shall be received by him not later than the midnight before the annual

meeting, and on the morning of said meeting he shall deliver them unopened to the special election committee for official inspection and count.

Section 7. — Candidates receiving the highest number of votes shall be declared elected.

DUTIES OF THE OFFICERS.

ART. V. The President shall preside at all meetings of the Society and of the executive committee, and shall deliver an address before the Society at the annual meeting.

In case of the absence or other disability of the president, his duties shall devolve on the vice-president by seniority, if present. And for that purpose the person receiving the largest number of ballots for that office, shall hold the seniority. Otherwise, on such member as the presiding officer shall appoint, or the meeting may select.

ART. VI. The Corresponding Secretary shall have the charge and custody of all letters and communications transmitted to the Society; and to him they should be addressed. He shall prepare and transmit whatever communications the Society or executive committee may direct, and he shall perform such other duties as may be assigned to him.

ART. VII. The Recording Secretary shall give notice and keep a record of all the meetings of the Society and of the executive committee. He shall insert in the notices of the annual and semi-annual meetings the names of those candidates for membership that have been reported to the executive committee. He shall have charge of all papers and communications belonging to the Society, and shall read at the meetings of the Society all such communications as the executive committee may direct. He shall notify the chairman of every committee appointed by the Society or executive committee, of his appointment, in each case stating the commission and the names of the committee. On or before the first of April, annually, he shall transmit to the treasurer a list of all who have become members of the Society during the year.

The Recording Secretary shall receive fifty dollars annually as a compensation for the labors and duties incumbent upon the office.

ART. VIII. The Treasurer shall solicit and receive all money due to the Society, together with all bequests and donations, and shall pay all bills after they shall have been approved by the executive committee, which approval shall be certified to by the recording secretary. He shall keep an accurate account of all receipts and expenditures, and shall give such bonds for the faithful performance of his duties as the Society may require. He shall submit his accounts to the auditor at least once a year, and shall annually make a statement of his doings and of the state of the funds in his hands, to the Society.

The Treasurer shall receive fifty dollars annually as a compensation for his services.

ART. IX. The Librarian shall have in his custody and charge all the books and apparatus of the Society. He shall keep an accurate register of the same, and arrange them in a proper manner, and shall make such disposition of them, from time to time, as the executive committee may direct, for the benefit of the members. He shall receive and record all donations made in his department to the Society, and shall make a report at the annual meeting.

ART. X. The Censors shall examine the qualifications of all persons presenting themselves for membership, and for that purpose shall hold meetings on the same days as the regular meetings of the executive committee, and at such other times as they may deem necessary. They shall verify the medical diplomas of all applicants for membership, and report the names of all approved candidates for membership to the executive committee at least three months before their election as members of the Society.

ART. XI. There shall be a Committee on the *Materia Medica*, who shall select remedies for proving, and shall, at the expense of the Society, obtain and distribute the same to its members, or such other persons as they may deem suitable. They shall receive and examine communications upon the *materia medica* from the members of the Society, and report thereon at any regular meeting.

ART. XII. There shall be appointed annually, by the executive committee, a Committee on Nominations composed of the president, *ex officio*, and four Society members at large, whose duty shall be to nominate two candidates for each of the twelve offices named in Art. IV., Section 1, and file a certified copy of the same with the recording secretary, at least sixty days before the annual meeting.

ART. XIII. There shall be a Committee of Publication, consisting of the president, recording secretary, and at least three other members, to whom all matter for publication shall be referred, and under whose direction it shall be issued; the expense of which shall not exceed in any year a sum designated by the executive committee.

ART. XIV. There shall be a Committee of Arrangements, whose duty it shall be to make such arrangements as will add to the interest and importance of the annual and semi-annual meetings, such as selecting a suitable place for the meetings, soliciting communications, appointing subjects for discussion, providing refreshments for members, etc., subject to the direction of the executive committee.

ART. XV. The executive and all other committees shall have power to fill their own vacancies.

MEMBERSHIP.

ART. XVI. Any person who has received the degree of doctor of medicine from a legally authorized medical institution, and who sustains a good moral character, may become eligible to membership after having been examined and approved by the board of censors. He shall be elected by ballot at the annual or semi-annual meeting, and his having signed the application for membership shall be considered equivalent to an agreement to abide by the by-laws. In case that ten negative ballots shall be cast, the name of the candidate shall be referred back to the board of censors, who shall make a thorough investigation, and report to the executive committee.

The same conditions of membership shall also apply to women having like qualifications.

All members in good standing who shall have paid their annual dues for twenty-five years, consecutive or otherwise, shall attain the rank or title of life-members, and shall be entitled to all the privileges of the Society, but shall be exempt from the payment of the annual assessment.

HONORARY AND CORRESPONDING MEMBERS.

ART. XVII. Persons who have excelled, or made any great advancement in medical or other science, may be elected honorary members; and physicians of eminence residing out of the state may be elected corresponding members of the Society by a two-thirds vote of the members present at any stated meeting, provided the said person shall have been approved by the executive committee. Honorary and corresponding members shall be entitled to the diploma of the Society, and to participate in its proceedings in meetings devoted to scientific subjects.

ART. XVIII. Every applicant for membership shall deposit with his application in the hands of the recording secretary, the sum of five dollars, and shall, upon his election, receive therefor the diploma of the Society, signed by the president and secretary. Should an applicant fail of election, the money shall be returned to him.

ART. XIX. Any member in good standing shall have the privilege of withdrawing from the Society by giving notice in writing of such intention, and paying all arrearages due to the Society.

RETIRED MEMBERS.

ART. XX. Members on removing from the state or retiring from practice, may, provided all their dues to the Society are paid, by a vote of the executive committee, be placed on the list of retired members,

and, as such, shall be exempt from any assessments and shall not receive, except by courtesy, any of the publications of the Society, nor be entitled to speak or vote at any of its meetings.

ART. XXI. Any person who has resigned his membership, or been placed on the list of retired members, may, on application in writing, be reinstated by a vote of the Society at any regular meeting.

Any member removing out of the state shall have liberty to retain his membership on paying his annual assessment.

EXPULSION AND DISCIPLINE.

ART. XXII. Any member may be expelled from the Society, or, having resigned his membership, may be deprived of his privileges by a vote of two-thirds of the members present at any regular meeting, upon charges of the following description, provided the charge or charges against him have first been considered by the executive committee, and provided he has been notified of the same by the secretary, and an opportunity has thereby been given him to make his defense before the Society: —

1. For any gross and notorious immorality or infamous crime under the laws of the land.

2. For any attempt to subvert the objects or injure the reputation of the Society.

3. For advertising, publicly vending, or pretending to the knowledge and use of any secret nostrum.

4. For advertising one's self, or knowingly allowing one's self to be advertised as possessing extraordinary powers or ability.

5. For any conduct which, in the opinion of two-thirds of the members present at a regular meeting, shall be dishonorable.

ART. XXIII. As the object of the Society is to improve the science of medicine, to increase the usefulness and influence of its members, and to secure greater harmony and friendship among them, therefore it is of the highest importance that each member should so conduct himself, both in his private and professional life, as to command the entire respect of his colleagues.

Every person who becomes a member is understood to take upon himself an obligation to communicate to the Society any discoveries he shall have made relating to the science of medicine or surgery, and to co-operate in such measures as may be adopted by the Society for the advancement of these sciences; and, on his refusal to do so, he shall be subject to such censure as the Society, by a two-thirds vote of the members present at a regular meeting, shall inflict.

DUES.

ART. XXIV. Every member of the Society, the recording secretary, corresponding secretary, treasurer, and life members excepted, shall be assessed annually five dollars, and such other assessments as a

majority of the members, at any legal meeting, may determine. Newly elected members shall not be liable to assessment during the year of their election.

DELEGATES.

ART. XXV. The executive committee may appoint delegates to other societies and associations whenever they may deem it advisable to do so; and such delegates shall receive certificates of appointment from the recording secretary.

Accredited delegates from other societies and associations shall be allowed to participate in the scientific deliberations of this Society.

MEETINGS OF THE SOCIETY.

ART. XXVI. The annual meeting of the society shall be held on the second Wednesday of April, and the semi-annual meeting on the second Wednesday of October, at 10 o'clock A. M., in such one of the cities or towns of the Commonwealth as the executive committee may determine. A special meeting of the Society shall be called by the president, on the written request of ten members, stating the object of said meeting. At all regular meetings of the Society thirty members shall constitute a quorum for the transaction of business.

ART. XXVII. The executive committee shall meet on the third Wednesday of April, July, October and January. At the first or annual meeting, the committees, the orator, substitute orator, necrologist and auditor shall be appointed for the ensuing year.

At the meetings of the executive committee, five persons shall constitute a quorum. A special meeting of the executive committee shall be called by the president, on the written application of three of its members.

ALTERATION OF BY-LAWS.

ART. XXVIII. All proposals for alteration of the by-laws shall be presented to the Society in writing, at a regular meeting; and shall be referred without debate, to a special committee of five, appointed by the president, who shall consider and report on the same to the recording secretary, at least thirty days before the annual meeting. He shall mail a printed copy of such report to each of the members with the programme of the annual meeting.

APPOINTMENTS BY THE EXECUTIVE COMMITTEE.

ORATOR.—J. HERBERT MOORE, M. D., Brookline.

SUBSTITUTE ORATOR.—WINFIELD SMITH, M. D., o n

NECROLOGIST.—FREDERICK A. WARNER, M. D., Lowell.

AUDITOR.—A. HOWARD POWERS, M. D., Boston.

Committee on Materia Medica.

Chairman, WALTER WESSELHOEFT, M. D., Cambridge.
NELSON M. WOOD, M. D., Charlestown.
F. B. PERCY, M. D., Brookline.

Committee on Clinical Medicine.

Chairman, J. P. RAND, M. D., Monson,
FREDERICK P. BATCHELDER, M. D., Boston.
ELMER H. COPELAND, M. D., Northampton.
WILLIAM T. HOPKINS, M. D., Lynn.
JOHN H. BENNETT, M. D., Pawtucket, R. I.

Committee on Obstetrics.

Chairman, SARAH S. WINDSOR, M. D., Boston.
GEO. H. EARL, M. D., Boston.
J. E. BRIGGS, M. D., Boston.
F. L. EMERSON, M. D., Dorchester.

Committee on Gynæcology.

Chairman, WM. F. WESSELHOEFT, M. D., Boston.
CARL CRISAND, M. D., Worcester.
J. K. WARREN, M. D., Worcester.
GEO. E. PERCY, M. D., Salem.
MARY B. CURRIER, M. D., Somerville.

Committee on Surgery.

Chairman, HORACE PACKARD, M. D., Boston.
W. S. SMITH, M. D., Boston.
GEORGE E. MAY, M. D., Newton Centre.
G. FORREST MARTIN, M. D., Lowell.
CARL CRISAND, M. D., Worcester.

Committee on Diseases of Children.

Chairman, CARROLL C. BURPEE, M. D., Malden.
FRANK A. HODGDON, M. D., Malden.
E. E. ALLEN, M. D., Charlestown.
LUCY APPLETON, M. D., Boston.
JOHN H. BENNETT, M. D., Pawtucket, R. I.

Committee on Ophthalmology, Otology, Rhinology, and Laryngology.

Chairman, GEO. B. RICE, M. D., Boston.
GEO. A. SUFFA, M. D., Boston.
JOHN H. PAYNE, M. D., Boston.
L. HOUGHTON KIMBALL, M. D., Roxbury.
GEO. H. TALBOT, M. D., Newtonville.

Committee on Insanity and Nervous Diseases.

Chairman, EDWARD P. COLBY, M. D., Boston.
GEO. S. ADAMS, M. D., Westborough.
J. F. BOTHFELD, M. D., Newton.
HENRIK G. PETERSEN, M. D., Boston.
ELLEN L. KEITH, M. D., Framingham.

Committee on Dermatology, Syphilology, and Genito-Urinary Diseases.

Chairman, S. H. BLODGETT, M. D., So. Lincoln.
F. E. CONSTANS, M. D., Brockton.
A. H. POWERS, M. D., Boston.
J. L. COFFIN, M. D., Boston.
O. B. SANDERS, M. D., Boston.

Committee on Registration and Statistics.

Chairman, T. M. STRONG, M. D., Boston.
WINSLOW B. FRENCH, M. D., Boston.
F. P. BATCHELDER, M. D., Boston.

Committee on Publication.

Chairman, FRANK C. RICHARDSON, M. D., (ex-officio), Boston.
J. P. RAND, M. D., (ex-officio), Monson.
JOHN L. COFFIN, M. D., (ex-officio), Boston.
F. P. BATCHELDER, M. D., (ex-officio), Boston.
F. L. EMERSON, M. D., (ex-officio), Dorchester.

Committee on Arrangements.

Chairman, FRANK C. RICHARDSON, M. D., (ex-officio), Boston.
J. P. RAND, M. D., (ex-officio), Monson.
JOHN L. COFFIN, M. D., (ex-officio), Boston.
F. P. BATCHELDER, M. D., (ex-officio), Boston.
F. L. EMERSON, M. D., (ex-officio), Dorchester.

Committee on Legislation.

Chairman, CONRAD WESSELHOEFT, M. D., Boston.
JOHN P. SUTHERLAND, M. D., Boston.
HERBERT C. CLAPP, M. D., Boston.
FRANK C. RICHARDSON, M. D., (ex-officio), Boston.

DELEGATES TO OTHER SOCIETIES.

Inter-State Committee of the American Institute.

CONRAD WESSELHOEFT, M. D., Boston.

JOHN P. SUTHERLAND, M. D., Boston.

American Institute of Homœopathy.

HENRY E. SPALDING, M. D., Boston.

GEO. H. TALBOT, M. D., Newtonville.

NATHANIEL W. EMERSON, M. D., Boston.

Maine Homœopathic Medical Society.

ALONZO BOOTHBY, M. D., Boston.

MARY F. CUSHMAN, M. D., Castine, Me.

J. H. SHERMAN, M. D., South Boston.

Vermont Homœopathic Medical Society.

GEORGE E. MAY, M. D., Newton Centre.

WINSLOW B. FRENCH, M. D., Boston.

New Hampshire Homœopathic Medical Society.

WALTER TUTTLE, M. D., Exeter, N. H.

N. R. PERKINS, M. D., Dorchester.

Rhode Island Homœopathic Medical Society.

J. C. SHAW, M. D., New Bedford.

H. C. CLAPP, M. D., Boston.

Connecticut Homœopathic Medical Society.

GEORGE S. ADAMS, M. D., Westborough.

O. W. ROBERTS, M. D., Springfield.

New York Homœopathic Medical Society.

N. EMMONS PAINE, M. D., West Newton.

J. P. RAND, M. D., Monson.

Pennsylvania Homœopathic Medical Society.

FRANK C. RICHARDSON, M. D., Boston.

REPORTS OF COMMITTEES.In October.

Materia Medica.

Surgery.

Ophthalmology, Otology, Rhinology and Laryngology.

Dermatology, Syphilology, and Genito-Urinary Diseases.

Gynæcology.

In April.

Clinical Medicine.

Obstetrics.

Diseases of Children.

Publication.

Registration and Statistics.

Necrologist.

Auditor.

Insanity and Nervous Diseases.

The Annual Oration is delivered at the Semi-Annual meeting in October.

PROCEEDINGS

OF THE

FIFTY-NINTH ANNUAL MEETING.

APRIL 12, 1899.

The fifty-ninth annual meeting of the Massachusetts Homœopathic Medical Society was held at Steinert Hall, Boston, Wednesday, April 12, 1899.

The meeting was called to order at 10.30 A. M., by the President, H. C. Clapp, M. D.

The records of the two previous meetings, the semi-annual and special, together with those of the Executive Committee were read and approved.

TREASURER'S REPORT.

The Reports of the Treasurer and Auditor were also read and accepted. The Treasurer reported as follows : —

Massachusetts Homœopathic Medical Society, in account with Winslow B. French, M. D., Treasurer.

CR.

Amount received from account 1897	\$2,088.28
Received from yearly dues	1,280.00
“ Interest Old Colony Trust Co.	10.51
“ “ Abington Savings Bank	31.28
“ “ East Weymouth Savings Bank	33.19
“ “ Weymouth “ “	27.30
Total receipts	<u>3,420.51</u>

DR.

Amount expended for use of hall	\$80.00
“ “ “ printing diplomas	144.95
“ “ “ caterer	196.70
“ “ “ reporting in N. E. Med. Gazette	100.00
“ “ “ testimonial for Dr. Clapp	75.00
“ “ “ salaries of treasurer and secretary	100.00
“ “ “ postage, stenographer, etc.	60.38
	<u>757.08</u>
Cash balance on hand April 12, 1899	<u>\$2,663.48</u>

Cash in treasury as follows :

Deposited in Savings Bank of East Weymouth	\$533.19
“ “ “ “ “ Weymouth	527.80
(The two items above constituting fund set aside.)	
Deposited in Savings Bank of Abington	781.23
“ “ Old Colony Trust Co. . . .	781.76
Cash on hand not deposited	40.00
	<hr/>
	\$2,668.48
Deduct fund from total amount	1,060.49
Actual working balance	<hr/>
	\$1,602.99

The Auditor, A. H. Powers, M. D., reported that he had examined the accounts of the Treasurer, finding them correct and fully verified.

The report of the necrologist, Frederick A. Warner, M. D., was read by title and referred to the Committee on Publication.

On motion of the secretary a vote of thanks was offered to Dr. F. A. Warner, necrologist, for his painstaking care in preparing the necrological reports for the Society for several years.

ELECTION OF MEMBERS.

On motion the Secretary was instructed to cast the vote of the Society for the following named applicants for membership :

Eliza B. Cahill, M. D., Boston.

Alonzo Gale Howard, M. D., West Roxbury,

Wesley Terrence Lee, M. D., Charlestown.

Ralph Walter Parker, M. D., Reading.

Frederick W. Colburn, M. D., Boston.

Everett Jones, M. D., Brookline.

Mary B. Currier, M. D., Somerville.

The President reported on behalf of the special committee appointed to prepare some expression of the Society in regard to original work by members of the profession, stating that the committee recommended that a gold medal be awarded to Dr. Solomon C. Fuller, in recognition of his researches as to the presence of morphine crystals in the blood of those addicted to the use of this drug.

The report of the committee was adopted and the President in well chosen words presented the medal in accordance with the wish of the Society. The report is as follows :—

The Massachusetts Homœopathic Medical Society at its annual meeting in April, 1897, voted to take from its treasury the sum of \$1,000 and to invest it as a separate fund. It was planned that a part or all of the interest should be used from time to time for such

purposes as should be decided upon by a vote of the whole society. It was stated that it would be given preferably for original work in medicine.

At the annual meeting of the society in April, 1898, a committee of the fund was appointed, consisting of Drs. N. Emmons Paine, Herbert C. Clapp and I. T. Talbot, which should report at times to the society the best uses of the interest of the fund.

In accordance with the direction of the society, this committee is prepared to make the following report:

First, That for the present, one-half of the interest should be returned to the principal, in order that there may be a gradual increase of the fund.

Secondly, We recommend that the first award of the society should be given to Solomon C. Fuller, M. D., on account of his discovery of morphine in the blood of morphine habitués, as explained in his article entitled "A Phenomenon Observed in the Blood of Morphino-maniacs," read at the meeting of the society at the Westboro Insane Hospital, January 11, 1899.

We recommend that the form of the award be a gold medal, bearing the inscription, "Awarded to Solomon C. Fuller, M. D., by the Massachusetts Homœopathic Medical Society, April 12, 1899, in recognition of his discovery of morphine in the blood of morphine habitués."

N. EMMONS PAINE, M. D.

HERBERT C. CLAPP, M. D.

I. T. TALBOT, M. D.

ADDITIONS AND AMENDMENTS TO THE BY-LAWS.

Proposed at the Semi-Annual Meeting, Oct. 12, 1898.

That there be *added* to Article I, the following words as found in Article XXIV, "to increase the influence and usefulness of its members and to promote harmony and friendship among them."

Article IV. Section 1, line 10,—that the word "oration" be substituted for "address", and "semi" be prefixed to the word "annual."

Lines 8 and 9, to insert after the word "expedient" the words "the appointment of a Necrologist and Auditor", and after the word "person" in the 9th line insert "and substitute."

Section 1, lines 13, 14 and 15, to strike out "and shall also furnish a list of two candidates for each office of the Society for the ensuing year." This change is proposed to conform to a proposed change in Article XV.

Sections 2 and 3. Change the word "executive" to "nominating."

Article V. Line 2, to insert the words "and nominating" after the word "executive." Lines 3 and 4, to strike out the words "the commencement of."

Article VI. Specific duties should be specified here. The following is offered as a suggestion to the Committee on Amendment and the Society. To insert after the word "addressed" in the 4th line, "He shall notify the chairman and members of every committee appointed by the Society or Executive Committee of their appointment, in each case stating the commission and the names of the other members of the committee." And Article VII, lines 10 to 14, to conform to this.

Article VII. Line 3, to substitute the words "insert in" for the words "append to."

Make such changes in Article VII as will conform to any changes made in Article VI.

Article VIII. Lines 9 and 10, to substitute for the words "such examination as the Executive Committee may direct" the words "to the Auditor for examination at least once a year."

Articles XI and XII. That in order to secure uniformity, brevity and precision, Articles XI and XII be replaced by the following, to be designated Article XI, (which simply states our present practice as to number of committees reporting):

"There shall be appointed annually by the Executive Committee, the following sectional committees composed of three or more members each, the duties of which shall be to receive and examine communications proper to their respective departments and to report thereon annually at such meeting of the Society as may be assigned by the executive committee.

Sectional Committees :—

1. Materia Medica.
2. Clinical Medicine.
3. Obstetrics.
4. Gynæcology.
5. Surgery.
6. Diseases of Children.
7. Ophthalmology, Otology, Rhinology and Laryngology.
8. Insanity and Nervous Diseases.
9. Dermatology, Syphilology and Genito-Urinary Diseases.

Additional sectional committees may be created by vote of the Society as indicated in Article XXIX (or XXVIII if renumbered.)"

Article XII. In place of the former Article XII, embodied in proposed Article XI, there be inserted,

"There shall be appointed annually by the Executive Committee a Committee on Nominations, composed of the President (ex officio,) and four Society members at large, whose duty shall be to nominate two candidates for each of the twelve offices named in Article IV,

Section 1, and file a certified copy of the same with the Recording Secretary at least sixty days before the annual meeting."

Article XIV. In view of the probable adoption of the plan of having a third meeting in January of each year, that the words "annual" and "semi-annual" be omitted, and that the words "appointing subjects for discussion" in the 6th line be erased, since this is the duty of the respective sectional committees.

Article XV. Strike out entirely, since we have a Librarian with practically nothing to do, and no such committee has been appointed for several years because not needed.

Renumber all articles after Article XV, or instead make "Librarian chairman of this committee."

Article XVII. Line 6, change "He" to "They." Line 7, change "his" to "their." Lines 14 and 15 strike out, because superfluous. Line 19, omit "hip" from the word "membership."

Article XXV. That if the Corresponding Secretary be given proper amount of work his name be included here if the Committee on By-laws deem expedient.

That there be added to this article the following, as adopted by the American Institute:—

"Members neglecting the payment of dues for three years, after proper notification from the Treasurer, shall have their names dropped from the roll of membership. Special cases mentioned in Article IV, Section 1, excepted. Any person thus dropped shall have the privilege of reinstatement on recommendation of the Board of Censors, by paying all arrearages."

Article XXVII. That the By-laws Committee to be appointed incorporate the proposed January meeting in the text of this article, if such meeting be continued.

That there be added to this article the following:—

"At all regular meetings of the Society twenty-five members shall constitute a quorum for the transaction of business."

Article XXVIII. That the time of the July or second meeting of the Executive Committee be changed to such time in June as the By-laws Committee recommend, since July is a vacation month.

That "and" in the fourth line be omitted, and there be inserted after the word "Orator" the words the "Substitute Orator, Necrologist and Auditor."

Article XXIX. To insert after "writing" in line 2, the words "at a regular meeting" and after the word "committee" in line 4, the words "of five, appointed by the President." To strike out the words "at the next annual meeting of the Society" and to substitute therefor "to the Recording Secretary at least thirty days before the annual meeting. He shall mail a printed copy of such report to each member with the programme of the annual meeting."

Dr. Foss' amendment to reduce the dues to three dollars.

The Committee on Revision of the By-Laws presented its report, and after a full and free discussion the recommendations were unanimously adopted.

REPORT OF COMMITTEE ON BY-LAWS.

Your committee has held two meetings and several conferences, and would report as follows :

The amendments numbered 1-26 are those offered by Dr. F. P. Batchelder, and will be reported in the original order.

No. 27 is the amendment offered by Dr. David Foss.

On No. 1, we do not recommend that it pass as the subject-matter appears elsewhere.

On No. 2. Recommend that it pass.

On No. 3. Recommend that it pass.

On No. 4. Recommend that it pass.

On No. 5. We do not recommend that it pass as it does not seem well to have so small a committee both nominate officers and the board which reports the election.

On No. 6. We do not recommend that it pass as in his absence it does not leave the nominating committee free to choose a chairman.

On No. 7. Recommend that it pass.

On No. 8. Do not recommend that it pass, as it will cause delay and increase the opportunities for error ; but he might be named to receive the votes by mail instead of the recording secretary.

On No. 9. Recommend that it pass.

On No. 10. Do not recommend that it pass as it belongs with No. 8.

On No. 11. Recommend that it pass.

On No. 12. Do not recommend that it pass. The Executive Committee is given authority to constitute scientific and other committees as the society may need them, and to omit any committee when it is for the best interests of a meeting or the society. By the amendment no such changes could be made without a six months written notice. We believe that the flexibility of this present rule has been of use to the society in the past.

On No. 13. Recommend that it pass.

On No. 14. Do not recommend that it pass, partly for reasons mentioned in No. 12 and partly because we do not think the January meeting has been sufficiently well tried to make it an item in the By-Laws.

On No. 15. Recommend that it pass.

On Nos. 16, 17, 18. Do not recommend that they pass, as it would demand other grammatical changes, and the article was made to read as it does for the purpose of accentuating our position in admitting women.

On No. 19. Recommend that it pass.

On No. 20. Recommend that it pass.

On No. 21. Do not recommend that it pass, as such hard and fast rule would in past years have lost us several members from whom we afterwards collected arrearages.

On No. 22. Do not recommend that it pass as we are not sure of its success, and we believe the expense incurred could be better applied to encouraging scientific investigation (as it now appears.)

On No. 23. Recommend that it pass, but that the number be made thirty.

On No. 24. Do not recommend that it pass as the previous meeting is later in April and June follows it too soon.

On No. 25. Recommend that it pass.

On No. 26. Recommend that it pass.

On No. 27. Do not recommend that it pass. The society might possibly pay its expenses on this basis but if we publish transactions, elect officers by mail, have our meetings in hired halls, and also have two lunches each year we gravely doubt it. We also cannot sympathize with this commercial spirit which values our privileges at only three dollars. We have been over forty years raising a fund of \$1,000 toward the encouragement of science.

E. P. COLBY, M. D., *Chairman.*

JOHN L. COFFIN, M. D., *Secretary.*

C. L. NICHOLS, M. D.

J. P. SUTHERLAND, M. D.

O. B. SANDERS, M. D.

The committee on election reported that the following had been duly elected to serve as officers of the Society for the coming year.

President, Frank C. Richardson, M. D.

Vice-Presidents, J. P. Rand, John L. Coffin, M. D.

Corresponding Secretary, Frederick P. Batchelder, M. D.

Recording Secretary, Frederick L. Emerson, M. D.

Treasurer, Winslow B. French, M. D.

Librarian, J. Wilkinson Clapp, M. D.

Censors, Herbert C. Clapp, M. D., E. P. Colby, M. D., H. P. Bellows, M. D., Horace Packard, M. D., Frederick B. Percy, M. D.

PRESIDENTIAL ADDRESS.

BY H. C. CLAPP, M. D., BOSTON, MASS.

Ladies and Gentlemen of the Massachusetts Homœopathic Medical Society: —

When we, as a society, review the history of Homœopathy in Massachusetts during the year which ends today, three events of especial interest to our cause seem to stand out in prominent relief.

First: — The old State Board of Lunacy and Charity, which, in the conduct of its affairs, had given great dissatisfaction in many quarters in other respects, and which, (as more particularly concerns us,) had by gross misrepresentation tried to explain away and deny our superior success in the treatment of the insane at our hospital in Westborough, and to make unfounded charges against that institution, this proud board was, in the year just passed, made to step down and out, and by a kind of retributive justice, the chairman of the board of trustees of our Westborough hospital, who, in his representative capacity, had been the target for the assault, was made a member of the new State Board of Insanity which replaced the old Board of Lunacy and Charity, so far as the treatment of the insane was concerned.

Second: — Our Commonwealth through its Legislature as if to resent the insinuations just referred to, and as a further expression of approval of the good work done there by the Homœopathic profession has completed within the past year, at a cost of more than \$50,000.00, on the grounds of our Westborough Hospital, a new and handsome building, complete in all its appointments, for the isolation and treatment of the acute insane. At the extra mid-winter meeting of this Society which was held at this hospital in January last, those of you who were present had an opportunity to examine this new building. Valuable as it is, however, it is but the natural outgrowth of the policy of the State with regard to an institution which has been in active operation on the same lines for more than a dozen years.

Third: — By far the most important public measure in the advancement of Homœopathy during the past year, marking as it does an entirely new departure in the policy of our government, has been its

recognition by the State of Massachusetts, on an equality with the system of the old school, in the opening of the new and large

MASSACHUSETTS HOSPITAL FOR CONSUMPTIVES AND TUBERCULAR PATIENTS AT RUTLAND, MASS.,

in its remarkably beautiful and healthful location in the geographical center of our state. A part of my excuse for dwelling particularly upon this third division of my subject is that "out of the abundance of the heart the mouth speaketh."

This is the only instance where our Commonwealth gives practical recognition to the two schools side by side, although the practice of establishing and endowing by private munificence such joint hospitals in our smaller cities and towns, notably in Newton, Chelsea, Malden, Somerville, Brockton, Lowell, etc., has been becoming rather popular.

This Rutland hospital was opened just six months ago and has already become an established institution. The board of Trustees comprises two medical men, one an honored member of this society, and the other a broad-minded member of the Mass. Medical Society; together with three liberal laymen, one a lawyer, one a manufacturer, and the other an editor. Acting under the requirements of the act of the Legislature which created this board, they appointed, to have supervising charge of the medical treatment, one visiting physician of the old school and one Homœopathist with equal rights and privileges, and also graduate internes or house physicians of like diversity. The Superintendent and Matron are fair and impartial, and the nurses have been trained in hospitals of both kinds. Up to the present time there has been no clashing and the greatest harmony prevails.

While the hospital was filling up, patients on entering were assigned to successive beds without distinction as to modes of treatment. In other words, the sheep and the goats, the wheat and the tares, the lions and the lambs, provided they were of the same sex, were mixed up together like this metaphor.

For obvious reasons, no detailed report can yet be made; but what has happened so far gives promise of many recoveries. Already, even in this short time, there have been a few cases which have been apparently cured, and others in which the disease appears to have been arrested,—for how long a time it yet remains to be seen. The cases of improvement have been so numerous as to include the great majority, in spite of the fact that often, especially at first, cases were received which were undesirable because too far advanced. In future it is proposed to draw the line more strictly and to receive only incipient cases or those which have made little progress. The decrease in fever, cough, expectoration, blood-spitting and night sweats, and the increase in appetite, digestive and assimilative power, strength

and weight have been so marked and so frequent that in many cases they are now looked for almost as a matter of course.

Recovery is not expected in every instance. No such extravagant and ridiculous claims are made. No magic wands are waved, no marvelous incantations are uttered, no weird subterranean powers are summoned, no secret or occult influences are invoked. No principles or methods of treatment are employed except such as might be proclaimed from the housetops.

And yet, the opinions of those most competent to judge, of those who have treated the disease for years in our cities and larger towns, especially among the same class of people as most of the Rutland Hospital patients, are and must be, that for some reason or other physicians in cities lack the peculiar advantages which Rutland possesses, which accounts for the comparative failure in their treatment. For certainly, we must all admit that, of our patients with limited means who have been treated for recognized phthisis at their homes in our more thickly settled communities, (no matter how early in the disease they may have been seen,) very few have recovered; the great majority even of incipient cases going from bad to worse before our very eyes. I doubt if any one will controvert this statement, unless it be the man who during a large practice of thirty or forty years duration has never lost a case of pneumonia, or of diphtheria, either before or after the discovery of antitoxine.

Consumption is a terrible disease and cannot for many years at least, if ever, be robbed of all its terrors, in spite of the best medicinal hygienic and climatic treatment; in spite of all actual or possible new discoveries in science; nevertheless, those who have observed and are in a position to know, whether in this country or in Europe, feel confident of the superior efficacy of the modern sanatorium in the treatment of phthisis.

Now in what does this superiority consist? Surely not in the medicines used, for they are the same as those used by practitioners in all of our cities and towns. The dietetic treatment in sanatoria is important, but except as the digestion and assimilation of food are more or less dependent upon the conjoined measures employed there, it can be carried out anywhere, as can also the baths and other hydropathic measures and massage, as well as the breathing and other exercises, if only people would do it. The regulation of a consumptive's exercise and rest according to well-defined principles, is a matter of vital moment, and yet on this point much ignorance prevails among the medical profession, in consequence of which many lives are undoubtedly lost. Still, if the physician realizes its importance and will give enough time to it, it can be utilized for the patient, wherever he may live. Yet more important, but more difficult to manage at the patient's home, is the effort to procure an unbounded supply of pure *fresh air* direct from nature's laboratory, by day and

by night, in winter and in summer, in spring and in fall, in season and out of season. Satisfactory arrangements for this are hard to obtain in our cities and large towns. Even if their environment were not particularly unfavorable, as they would be from bleak east winds just off the ocean, from density of population with accompanying abundance of noxious germs of various kinds, from volumes of smoke and dust, from dampness of soil, etc., it is not easy to provide proper piazza space for day reclining, with the best sun exposure and sheltered from the worst winds, nor indeed do such patients often have sufficiently large sleeping rooms. Still, these obstacles are sometimes and to some extent surmountable; although in comparison with the deliciously pure and bracing, germ-free, elevated air of Rutland and some other localities, the air of such places is at best second or third or fourth class. Contrary to the opinion of some, even such city air, by night or by day, is vastly superior to the bad air breathed and re-breathed, over and over again, in which so many people seem to revel.

In what has already been presented, a part of the advantages of the sanatorium treatment (which sometimes can also be obtained at home) has been hinted at; but by far the most important benefit to be derived from a sanatorium is the opportunity there provided to regulate the patient's conduct and life by *the discipline* of the place. Even if the physician finds that all of the benefits above referred to, and others as well, can be secured to his patient at home, (as rarely happens) yet he never knows whether or not his prescriptions are followed in detail. In many cases the patient uses his own judgment and frequently makes exceptions for what seems to him good and sufficient reasons. The will-power in this disease is often weakened as well as the body, and he finds it easy to make excuses to himself for neglecting the plain path of duty. If any one doubts this tendency, let him look back on his own life and try to recollect how often, not only on January first but on many other days, without even the pretext of will-power weakened from tuberculosis, he has made good resolutions and promised himself to pull those chest weights and swing those Indian clubs in his bedroom so many times a day, for the development of his own muscle or for the relief of his own sedentary infirmities.

On the other hand, in a sanatorium a certain amount of military discipline prevails. The patient's life is a regular one, his duties are those of an established routine, and he does them the more easily because others by his side are doing the same things. Indeed, the keynote to the whole situation is the fact that, instead of being left to use his own judgment, he is practically under the thumb of the physician and his assistants, though not in an offensive sense; for he is a willing captive and gives his cordial co-operation in all the requirements, knowing full well that every one concerned is anxious with

him for his recovery. If he cannot take the discipline, he leaves the institution.

The night nurse, acting under instructions, keeps the windows open just so wide, no matter what the judgment of the patient may dictate. The latter lies abed, reclines in his steamer chair in the sun-room or on the veranda, and takes walks or other exercises according to directions, and there are those nearby whose duty it is to see that these directions are carried out. The nearer he gets to becoming a well man, the more liberty he has to regulate his own affairs. That this routine and discipline are not onerously irksome, and that the aggregation and close association of a large number of consumptives in one institution are not mentally depressing, as many people without experience theoretically imagine, can be easily proved by a visit to Rutland on any day, when demonstration will be forthcoming that it is one of the happiest communities in the world, at least to all external appearances.

That our new State Hospital, (or Sanatorium as we like to call it) will in the years to come save many lives and return them to their dear ones, that it will, from a pecuniary standpoint, restore many wage-earners to the support of their families, thereby adding also to the productive labor of their towns, counties and state, that it will so arrest the disease in its graduates as to enable them to live right here where they want to live instead of in Colorado or Arizona where their disease might have been arrested but where they might not care permanently to reside, and that, where lives cannot be saved they may be prolonged by such treatment, is our fond hope and belief. But we are not satisfied merely with these closely related benefits. We like to consider our hospital not merely a Sanatorium, but also a great *Normal School*, whose graduates having there learned how to live will become teachers in the communities in which they may settle, teachers of the laws of hygiene and healthy living, demonstrators of the importance of the destruction of tuberculous sputum, and apostles of the gospel of pure, fresh air especially to consumptives and more especially still to those of consumptive tendency, for it is far easier and far better to prevent than to cure.

That there is need of missionary work in this direction, not only foreign, but also, (we must confess) home missionary work, is beyond question. The air in our steam cars where some of us spend so much time is often vile beyond description. Our public halls, churches, lecture rooms, libraries, theatres, steamboats and many other places are sometimes unbearable, and the air in all of them has often been proved to contain tubercle bacilli in abundance and of such virulence as to cause tuberculosis when injected into Guinea pigs, rabbits, etc.

Our graduates have been so thoroughly soaked in pure, delicious, fresh air that they learn to love it as the hunter loves camp life. Some of them may learn to teach something about dietetics, some to

teach hygiene, but all can learn to preach the virtues of fresh air ; and if they become cranks upon this subject, so much the better chance they have of drawing the people up somewhere near the proper line.

It may be said that it is not necessary to take a course in a consumptive's hospital to be able to teach the virtues of fresh air ; but I have an idea that a man who has become a thorough master of the bicycle can better instruct another in riding than can one who has never been on the machine himself, but who teaches it from theory only. Almost every man claims to believe in ventilation and has done so for years, and yet many places all around us continue to reek with foulness. It is the hardest thing in the world to persuade many consumptives at home to furnish themselves with fresh air. They are constantly afraid of taking cold. I have often thought how nice it would be if foul air could be seen like smoke, as well as smelled, especially by those whose olfactories are not very acute. Probably, however, this sight would not be enough, as smoke does not always intimidate. Better might be the effect, if the foulness showed itself as large particles of visible dust, or if it took to itself wings and hung in the air as innumerable living bugs, each intent upon mischief, the patient not having imbibed ! Would that each consumptive might learn to dread the smell of bad air as some people now dread the smell of ether on account of a suggested surgical operation, or of carbolic acid or of other disinfectant on account of a suggested contagious disease. If they lack everything else, yet give them a longing for plenty of fresh air, such a longing as had Arabella Willson more than a generation ago, expressed in her classic poem which I quote, showing that then as now and now as then a bad environment often attaches to a so-called good place.

“ O, Sextant of the meetin-house, which sweeps
And dusts, (or is supposed to) and makes fires
And lites the gass, and sometimes leaves a screw loose,
In which case it smells orful, worse than lamp ile,—
But, O Sextant, there are one kermoddity
Which's more than gold, which doant cost nothin,
Worth more than anythin except the sole of man !
I mean pewer are,— I mean *pewer are*.

It's plenty out of doors, so plenty it doant no
What on airth to dew with itself, but flys about
Scatterin leaves and blowin off men's hatts.
But O, Sextant, in our church it's scarce as beauty,
Scarce as bank bills, when agints beggs for mischuns,,
Which some say is purty often,

(Taint nothin to me, what I give aint nothin to nobody.).

But O Sextant

You shet 500 men, wimmin and children,
Especially the latter, up in a tite place,
And every one brethes in and out, and out and in,
Say 20 times a minute, or 1200 breths an our.
How long will are last at that rate?
I ask you — fifteen minutes? — and then what shell be done?
Why then they brethe it over all agin,
And then agin, and so till each hes took it down
At least 10 times and let it up agin; and wat's more,
The same individoal doant have the privilege
Of brethin his own are and no one's else,
Each one must take whatever comes to him.

Are is the same to us as milk to babes,
Or water is to fish, or pendlums to clox,
Or roots and airbs unto an injun doctor,
Or little pills unto an omeopath,
Or boys to girls. Are is for us to brethe.
Wat signifies who preaches, if I brethe not?

REPORT OF NECROLOGIST.

FREDERICK A. WARNER, M. D., LOWELL, MASSACHUSETTS.

IN MEMORIAM.

JOHN T. HARRIS, M. D.

Dr. John T. Harris died at his home in Roxbury, August 23, 1898, after a short illness, aged 78.

Dr. Harris was born at Marblehead, Mass. Lived afterwards in Salem, where he married. He practiced dentistry for a time, and afterwards attended Hahnemann Medical College of Philadelphia, from which he was graduated in the year 1853. He commenced practice in Taunton and afterwards practiced in East Bridgewater and Abington.

About 30 years ago he removed to Roxbury, Mass., and soon built up a very large practice there. "The secret of his success as a physician was a power of which he himself was but partly conscious. It lay in the one word — insight. This was in fact a natural gift, but the general unselfishness of his nature furnished favorable conditions for its development. His good works were many and they bore the Master's own seal in secret." The natural warmth of his temperament made him an enthusiastic practitioner of medicine to the end of his days.

Dr. John T. Harris was a zealous member of the Church of the New Jerusalem. "And carried the supporting truths and comforting sphere of the 'New Church' into the homes of affliction."

His associations other than family and church were membership in the Massachusetts Homœopathic Medical Society and in the Joseph Warren Commandery of Knights Templar.

He leaves a widow and three daughters.

The funeral services over the remains of our departed brother were held in the Church of the New Jerusalem, Roxbury. The edifice was filled with members of the Medical Fraternity and delegations representing the Joseph Warren Commandery Knights Templar and Lincoln Council, American Legion of Honor. The services were conducted by the Rev. J. K. Smyth, pastor of the church. A quartet sang "Abide With Me," and "Nearer My God, to Thee." Grouped about the casket was a profusion of floral offerings. Among them was a cross and crown from Joseph Warren Commandery K. T., pillow from Lincoln Council, American Legion of Honor, wreath from friends at Cataumet, and numerous other tributes. The pallbearers were Doctors H. L. Chase, E. P. Scales, J. P. Edmond, G. H. Brackett,

J. H. Thompson, representing the societies of which Dr. Harris was a member. The Rev. Mr. Smyth delivered a brief eulogy in which he extolled the high Christian virtues of the deceased. At the close of the services, in accordance with Dr. Harris' expressed wish, his remains were taken to Forest Hills Cemetery.

The following from the pen of Prof. H. C. Clapp, written to the family in the time of their bereavement, illustrates the place he held in the hearts of the profession generally:

" 334 Commonwealth Avenue, Boston, Mass.,
August 24th, 1898.

Dear Dr. Gibbs : — I have been exceedingly pained and grieved to hear of the death of your father, as you know I have always thought a great deal of him.

I wish that there were many physicians just like him, as conscientious, faithful, self-sacrificing, able, industrious and really 'good.'

With a great deal of sympathy, I am, Yours very truly,
H. C. CLAPP."

Many letters reached the family from old patients and friends equally as strong in their testimony of the great worth of their beloved physician.

The Boston Homœopathic Medical Society adopted the following resolutions :

Whereas, Dr. John T. Harris, after a long life devoted to the faithful performance of his duty, has been called to his well-earned rest,
Therefore,

Resolved, That we, the members of the Boston Homœopathic Medical Society, testify to the high regard in which he was held in our midst, to our appreciation of his qualities of earnest devotion to his professional and other duties, his uprightness of character, his kindly disposition, and the good example he always set his colleagues and the younger generation.

Resolved, That we desire to express to his family and relatives our sympathy in this time of their bereavement, and to place such expressions upon the records of our Society.

ALONZO BOOTHBY, M. D.,
JOHN P. SUTHERLAND, M. D.,
ALONZO G. HOWARD, M. D.,
Committee.

SHADRACH M. CATE, M. D.,

Salem, Mass.

Shadrach M. Cate, M. D., was born in London, N. H., October 24, 1823. He was the son of Shadrach Cate, an esteemed and well-known citizen of that section of the state. His early years were passed in his home, making the best use of such educational advantages as were within his reach. When nineteen years of age he entered the office



Heber Smith

of his brother-in-law, Dr. Alpheus Morrill, then of Solon, Ohio. He pursued the usual course of study as a student of Allopathy, attending the Medical Department of the Western Reserve College at Cleveland, Ohio, during the sessions of 1844-45.

In the meantime, his attention and Dr. Morrill's had been attracted to Homœopathy. They investigated its claims, which resulted in both becoming zealous advocates of the new system. Dr. Cate supplemented his Allopathic course of study with a thorough knowledge of Homœopathic therapeutics, and was examined by the Board of Censors of the Ohio Homœopathic Medical Society, and admitted as a member, which, under the laws of that state, was a full license to practice medicine. In 1854, he graduated at the Western Homœopathic Medical College at Cleveland, and later was offered the chair of *Materia Medica* at that college.

In the fall of 1845 Dr. Cate and Dr. Morrill formed a partnership and moved to Columbus, Ohio, introducing Homœopathy in that city. Subsequently they both returned to New England, and Dr. Cate located in Augusta, Maine, in 1850, where he established an extensive practice. His health was not equal to the severity of the climate, and in 1860, at the suggestion of Dr. E. B. de Gersdorff, he succeeded Dr. Floton in Salem. He became a member of the Massachusetts Homœopathic Medical Society in 1861; gave the annual *address* in 1864, and was elected *President* of that Society in 1867. His practice in Salem covered nearly twenty-five consecutive years. During this period he spent one year in Vienna, devoting his time to study in the various hospitals of that city. The remaining years of active practice were passed in Salem and Washington, D. C. His medical career extended over a period of nearly half a century of the history of Homœopathy in this country.

The student of today will hardly realize that that carries us back to the pioneer work, when the first medical schools and institutions of learning were being established in this country, and probably will never understand the obloquy, persecution, prejudice and ridicule, the noble men of that time endured for the cause of science, truth and humanity.

Dr. Cate retired from active practice in 1890. The last years of his life he was in feeble health. He died April 22, 1898. His widow and three children survive him, the eldest son being Dr. W. M. Cate of Chicago, Ill.

PROFESSOR J. HEBER SMITH, M. D.

Again we are called to mourn the death of one of our most valued members, in the death of Dr. J. Heber Smith, Professor of *Materia Medica* in Boston University School of Medicine. Verily, a Prince in the House of Hahnemann has fallen. Great is our loss, great is our

sorrow and we cannot be comforted. The shadow that has fallen upon the Faculty and students of the Boston University School of Medicine, the Massachusetts Homœopathic Medical Society, and hosts of friends and patrons, is deep and dark, time alone being able to dispel it. How much we loved him; how highly we esteemed him can be seen from the following quotations recorded in the New England Medical Gazette, being an editorial and resolutions of various organizations with which Dr. Smith had been long associated.

EDITORIAL NOTES AND COMMENTS OF THE NEW ENGLAND
MEDICAL GAZETTE.

Dr. J. Heber Smith, Professor of 'Materia Medica in the Boston University School of Medicine, died at his home in this city, October 23, 1898, of heart disease. Dr. Smith, the son of a well-known Methodist clergyman, the Rev. Joseph Smith, was born in Bucksport, Maine, December 5, 1842. Fitted for a classical education at Harvard University, he was prevented from pursuing a collegiate course by ill health, and a few years later he began the study of medicine, graduating from the Hahnemann Medical College of Philadelphia in March, 1864, being the valedictorian of his class. He began the practice of medicine in Melrose, Mass., where he continued till 1882, when he moved to Boston. Since the foundation of the Boston University School of Medicine Dr. Smith has been a potent factor in its development, having held almost continuously the chair of Materia Medica, and for the past twenty years has been a member and secretary of the executive committee of the Faculty. As to his ability, faithfulness and enthusiasm in this work his colleagues amply testify elsewhere in these pages. Dr. Smith was a member of the American Institute, the Massachusetts Homœopathic Medical Society, and one of the original members of the Boston Homœopathic Medical Society.

We count it as one of the privileges of our life to have known Dr. Smith almost ever since our first acquaintance with Homœopathy. He was a man in many respects of rare and exceptional attainments. With a most remarkable memory, even for fine details, he was unusually acute, brilliant and humorous, and stamped his charming personality and individuality indelibly upon the minds of those with whom he came in contact. Above all and through all he was a Homœopath first, last and always. The profession throughout the country is immeasurably poorer for his loss.

ACTION TAKEN BY THE FACULTY OF BOSTON UNIVERSITY SCHOOL
OF MEDICINE ON THE DEATH OF DR. J. HEBER SMITH.

On Tuesday, October 25, 1898, at twelve o'clock, the Faculty of Boston University School of Medicine held a meeting at the school building to take action on the death of Prof. J. Heber Smith.

The meeting was presided over by the Dean, Dr. I. T. Talbot. Dr. H. C. Clapp read an article presenting a brief biographical sketch of Dr. Smith. Members of the Faculty then testified, each in a few words, to their appreciation of the many qualities possessed by their late colleague. They spoke of his great courage, of his striking faithfulness to the school, of the clearness of his teaching, his constant cordiality and cheerfulness, his magnetic personality and many other noble and lovable traits which had won for him the regard of Faculty and students alike. Dr. Richardson, when called upon for remarks, read some verses by the late Sherman Hoar, beginning,

"Give unto thy servant rest,"

which seemed to be particularly appropriate to the occasion.

The following resolutions, which had been prepared by a committee previously appointed, were read by Dr. Sutherland and unanimously adopted by a rising vote:

J. Heber Smith, physician, medical teacher, friend, having been called by the dispensation of the Eternal Wisdom from his earthly labors, his surviving colleagues on the Faculty of Boston University School of Medicine mourn his death, honor his memory, and hereby testify to their deep appreciation of his quarter of a century's unremitting, steadfast, and faithful labors in behalf of the school. In classroom, in business meeting, in social gathering, his clear and efficient teaching, his words of counsel, and his genial presence will be sadly missed. His strong individuality, his unfailing cheerfulness, constant good humor, and pungent wit, united with his scholarly attainments made him a convincing personality. His patient and uncomplaining submission to lifelong infirmity, his sympathetic and keen appreciation of the sufferings of others, his energy and forgetfulness of self in ministering to the necessities of others will linger as an example to be imitated by all whose good fortune it was to know him.

To his family and relatives we extend our sincerest sympathy for a bereavement which is an affliction shared by all who were numbered with his friends.

J. P. SUTHERLAND, M. D.,
H. C. CLAPP, M. D.,
J. W. HAYWARD, M. D.,
Committee.

The following members of the Faculty acted as honorary pallbearers: Doctors Talbot, Sutherland, Conrad Wesselhoeft, and H. C. Clapp.

**ACTION TAKEN BY THE STUDENT BODY OF BOSTON UNIVERSITY SCHOOL
OF MEDICINE ON THE DEATH OF DR. J. HEBER SMITH.**

At a meeting of the student body of Boston University School of Medicine held Monday, October 24, 1898, the following motion was unanimously passed:

"That a committee of four, to consist of one member from each class, be constituted to draft resolutions to the memory of Prof. J. Heber Smith. That a copy of these resolutions be presented to the family of Dr. Smith, another to the Faculty of this school, a third given to the press, and that they be spread upon the records of each class."

RESOLUTIONS.

It is with a due sense of the inadequacy of words that we would express the profound sorrow which we feel at the calamity which we, as students in this school, have sustained in the death of Prof. J. Heber Smith, M. D.

With deep gratitude we shall ever remember the cheerful fortitude, courageous faithfulness, the scientific ardor, which, despite his physical disabilities, he unfailingly manifested in the discharge of his duties to us.

We ever found in him a wise counsellor, a sympathetic teacher, and a faithful friend, and we shall ever find in those qualities which endeared him to us a constant, helpful and sustaining inspiration.

To those of his family who have been left behind we extend our keenest sympathy; and while sorrow comes closer to them than to us, the feeling of gratitude which we sustain for his many kindnesses and brilliant teaching we believe cannot be exceeded.

A. E. P. ROCKWELL, 1899,

W. H. WATERS, 1900,

A. R. MANN, 1901,

W. L. KERSHAW, 1902,

Committee.

The following resolutions on the death of Dr. J. Heber Smith were adopted at a regular meeting of the Boston Homœopathic Medical Society:

Whereas, It has been in accordance with the inscrutable plans of an all-wise Providence to remove from our fellowship our dearly beloved friend and colleague, Dr. J. Heber Smith,

Therefore, we, the members of the Boston Homœopathic Medical Society, do

Resolve, That in his translation to a more exalted field of duty, we are deprived of the comfort and usefulness of his valued presence. In times of adversity he was a staff upon which we could lean. In times of success he was always a cheerful and acceptable participator. His absence from our midst leaves a void in our hearts which can be but imperfectly filled by pleasant memories.

Resolved, That we tender to his bereaved family our sympathy in their great loss.

EDWARD P. COLBY, M. D.,

CONRAD WESSELHOEFT, M. D.,

FRED B. PERCY, M. D.,

Committee.



H H Rand

NEHEMIAH WHEELER RAND, M. D.

Born in Francestown, N. H., September 14, 1853.

Died in Monson, Mass., November 5, 1898.

BY F. P. BATCHELDER, M. D., BOSTON, MASS.

Dr. Rand was the son of Thomas Prentice Rand and Lydia Wheeler Rand, and a descendant of Robert and Alice Rand, who came from England in 1635, and settled at Charlestown, Mass.

In his boyhood he attended the public schools of his native town and also the academy. Subsequently he engaged in school teaching, and also took partial courses in Dartmouth College and Boston University School of Medicine. He later entered the New York Homœopathic Medical College, from which he graduated in 1878.

He practiced medicine for a few months in Palmer, Mass., with Dr. John K. Warren, now residing in Worcester, and removed to Monson February 15, 1879, where he built up a large practice.

He was married on July 20, 1883, to Jennie, daughter of the late Luther B. and Lucinda C. Peck, and with his bride spent a year in study and recreation in Europe.

Two children were the fruit of this happy union, Frieda and Carl Wheeler. Mrs. Rand died April 21, 1886, mourned by her beloved husband and a large circle of friends.

For several years his brother, John Prentice Rand, M. D., now of Worcester, was associated with him in practice.

During his residence in Monson he had endeared himself to all the people. His pastor says: "Dr. Rand was a man of whom people became fond. To my mind this is the quality we shall chiefly miss in the community and in the home. Who shall come among us able to gather unto himself so large a measure of affection from the men, women and children of our town? Now this trait is all the more remarkable when we remember he was a progressive man, and of some positive convictions which he took no pains to conceal. In matters political, theological, administrative, educational and social he has often stood with the minority of his townspeople, but in these conflicts of opinion did you ever know him to lose one solitary friend? A lovable man. This modest wreath his pastor would lay upon his bier."

As a physician he had won the confidence and esteem of a large circle of patrons and friends. Among his colleagues his opinions were eagerly sought, and received the consideration they so well merited. He was ever ready to make personal sacrifice for the good of others.

He was an active member in each of the medical societies to which he belonged. He became a member of the American Institute of

Homœopathy in 1881, and of the Massachusetts Homœopathic Medical Society in 1880, and was for many years a member of the Homœopathic Medical Society of Western Massachusetts and the Worcester County Homœopathic Medical Society.

In the Massachusetts Homœopathic Medical Society he had served as one of the vice-presidents, and was one of the board of censors at the time of his death.

He was the chairman of the Bureau of Surgery of the Worcester County Society, which reported at the meeting of November 9, 1898. It is a striking coincidence that two of the papers upon the programme he had prepared were upon appendicitis, the very malady which caused his death. He had been chosen by the Faculty of Boston University School of Medicine to deliver a special course of lectures upon "fevers" during the present school year.

In the town of his adoption he served upon the school board for twelve years, and was its chairman for the past nine years. This gave unlimited scope to his love for and interest in children.

As a father it has been said of him: "He was his children's companion as well as their guide and protector."

As a poet he wielded a ready pen. The major portion of his poems may be found in "Random Rimes," published in 1897.

As a Christian, his faith in the Eternal was both sure and steadfast, as is well-voiced in the following quotation from his favorite poem:

"I know not where His islands lift their fronded palms in air;
I only know I cannot drift beyond his love and care.
And so beside the Silent Sea I wait the muffled oar;
No harm from Him can come to me, on ocean or on shore."

The loss to the community is but an index of the deeper sorrow in his own family circle. Beside the son and daughter he leaves a brother, Dr. John Prentice Rand of Worcester, and three sisters, Hattie, of Monson, who has rendered loving and faithful care in his household since the death of his wife; Sarah, of Worcester, and Mrs. William Clark, of Lyndeboro, N. H.

The funeral services were conducted at his late residence on Tuesday, November 8, at 2.30 P. M., during which all business in the town was suspended, and the public schools and Monson Academy were closed. Before the services began hundreds of school children and friends passed through his home for a last glimpse of the face of one who had been their friend and counsellor.

His pastor and other clergymen rendered most fitting tributes of love, and several selections from his own poems were read.

No more fitting words could have been spoken than the lines composed by him concerning the death of a brother physician, and these close with the following:

Dear friend! we'll not forget,
There was so much of the divine,
Commingled with this dust of thine,
That e'en its resting place benign
Doth now become faith's well befitting shrine;
We'll not forget.

Live on, O loyal heart!
Thy friends will never let thee die,
While love retaineth memory;
Virtue is heir to earth and sky,
And lo! she pledgeth immortality;
Brave soul, live on!

And we shall meet again,
Silently journeying, one by one!
After the labors of day are done,
We'll meet thee at the setting sun,
Be there, O friend, as wide its gates are flung—
We'll meet again.

DR. ORREN S. SANDERS.

Dr. Orren S. Sanders died at his home, 511 Columbus Avenue, Boston, Mass., November 20, 1898, of senility. He had been in constant practice up to within eight weeks of his demise.

Dr. Sanders was born in Epsom, N. H., September 24, 1820. He studied medicine in the Castleton Medical College, Vermont, graduated in 1843. He also attended Dartmouth College, from which he received an honorary degree in 1886.

He established himself first in Effingham. A year and a half later, in the autumn of 1849, he came to Boston, where he had since remained.

He was associated for a year and a half with Dr. Samuel Gregg, from whom he took his first lessons in Homœopathy, and then went into private practice at 11 Bowdoin Street. Here he lived for twenty-one years, when he moved into his late residence on Columbus Avenue.

Dr. Sanders was one of the three seniors belonging to the Homœopathic medical profession in Boston, and the community as well as his school recognized him as one of its most successful members. He was a member of the Massachusetts Homœopathic Medical Society (of which he had been president), the American Institute of Homœopathy, the Hahnemann Club, and the Boston Physiological Society, and had contributed largely to the medical journals. For two years he was a member of the Boston school committee.

He was a large contributor to many charities. He conceived the plan for and subscribed \$5,000 toward founding the Little Wanderers' Home. He was a 32d degree Mason, A. A. S. R., and had passed all the honorary positions in that body. He had always been a constant church supporter, and had given largely to the Union Congregational Church, of which he was a member. He leaves a widow.

The following resolutions were adopted by the Boston Homœopathic Medical Society:

Whereas, The hand of Providence has removed from his field of labor and from our presence Orren S. Saunders, M. D., we, the members of the Boston Homœopathic Medical Society,

Resolved, That we hold in kindly remembrance the many noble qualities, as man and physician, of our late colleague.

That we sympathize with the large number of patrons who had learned from long experience to look upon him as their worthy and beloved physician.

That especially do we sympathize with her who mourns the loss of a devoted husband.

Resolved, That these resolutions be placed upon the records of the Society, and that a copy be sent to the family.

S. A. SYLVESTER, M. D.,
H. E. SPALDING, M. D.,
H. P. BELLows, M. D.,
Committee.

HORATIO M. HUNTER, M. D.

Dr. H. M. Hunter, of Lowell, a senior in the State Society, died in Lowell, Mass., on January 11, 1899. We append the following from the Lowell Mail of January 11:

"Horatio M. Hunter was born September 29, 1830, in Lyndon, Vt., the son of James and Lucy Hunter. He first read medicine at Lyndon in the office of C. B. Darling, M. D., who was a pioneer Homœopath of Northern Vermont. After receiving an academic education Dr. Hunter went to Dartmouth Medical College and afterwards to the Hahnemann Medical College of Philadelphia from which he was graduated in the class of 1857. After leaving college he first practiced medicine at Concord, Vt., from which place he later went to St. Johnsbury, Vt. He left the latter place in 1870 and came to Lowell, where he has since been in practice."

Few, if any, physicians now here were then in practice in this city. In all these years Dr. Hunter was never known to shirk a duty, be it ever so difficult or trying. He had the respect of all who knew him; enemies he had none, for his sunny peaceful nature would not permit him to make them. He had always been a hard worker, fond of his

books and well acquainted with their contents; always keeping well abreast of the times, he gave to his patients the best there was in him.

Dr. Hunter was married in 1860 to Miss Susan M. Chase, of Concord, Vt. She, with one daughter, Mrs. G. Forrest Martin, and three brothers, and one sister residing in Vermont survive him.

Dr. Hunter was a member of the Lowell Hahnemann Club, and was its first president. He was also an active member of the staff of the Lowell General Hospital, and had served upon its Advisory Board ever since the hospital has been opened. He was a senior in the Massachusetts Homœopathic Medical Society and one of the founders of the Massachusetts Surgical and Gynæcological Society. He had also been a member of the American Institute of Homœopathy for many years.

During his residence in Lowell he was a constant attendant at the First Universalist Church."

A special meeting of the Lowell Hahnemann Club was held Thursday afternoon in the office of Dr. E. H. Packer, to take action on the death of Dr. Horatio M. Hunter. The following resolutions were presented and adopted:

"*Whereas*, An all-wise Providence, He who does all things well, has decreed that our friend and colleague, Dr Horatio M. Hunter, should be taken away, therefore we, the members of the Lowell Hahnemann Club, have met in special session to give expression to our feelings of sorrow at this sad occurrence. In the death of Dr. Hunter our Society has a vacancy created which no one can ever fill, for there was in him a diversity of manly and noble traits combined with the greatest of skill, the utmost devotion to his work, and the broadest views of his duty, which made him indeed the true physician. He went about doing good.

"Where others would have held back because of the sufferings and infirmities which he fought in later years, he never withheld his services, but went about his work day after day, when he was more in need of a physician than many of those to whom he administered.

"He knew no rich, no poor. He never complained of his cares, but cheerfully endeavored to lighten the burden of others. His one aim was duty, and he always performed it. He was one of nature's truest noblemen, God's noblest work. The community at large, and especially that large portion which has always looked to him for counsel and advice, has met with an irreparable loss. Dr. Hunter cannot come back to us but his memory will always be an incentive to us to do our duty. To his stricken family we extend our deepest, sincerest sympathy."

On motion it was ordered that the resolution be spread upon the records of the Society and a copy be sent to the family. It was also voted that the club attend the funeral in a body and that reports of the meeting be furnished the Lowell papers, the New England Medical Gazette, and the Philadelphia Hahnemannian.

G. L. VAN DEURSEN, M. D.

Secretary.

NEW ENGLAND MEDICAL GAZETTE.

It is our painful privilege to chronicle with this issue the deaths of two more of our older and best known physicians, Dr. Hunter, of Lowell, and Dr. Henry Houghton, of Boston. By rather a remarkable coincidence they were born in the same town, Lyndon, Vt., and died within a few days of each other. They were both widely known and beloved, were both very successful practitioners, and were both filled with that divine spirit which placed professional honor and duty ever in the front. They were both men of the older type, daily becoming less in number. Have we those who in character and devotion to duty can hope to fill their places? Who can say? God grant that we may ever keep the memory of such noble lives before us "lest we forget, lest we forget."

DR. HENRY A. HOUGHTON.

Henry Arvin Houghton, M. D., after a brief illness, died at his home, 136 Marlboro Street, Boston, January 15, and so ended a life of rare activity, fidelity and usefulness.

Dr. Houghton was born in Lyndon, Vt., December 25, 1826. After an academic training he entered the medical school in Philadelphia and graduated in 1852. The same year he married Sarah D. Page, of St. Johnsbury, and commenced his professional work in his native town. He soon removed to Keeseville, N. Y., where he found a larger field which he faithfully cultivated till 1876, when he came to Charlestown. Here his ability and the value of his services were soon recognized and he entered upon a large and successful practice, which he continued until within a few days of his death. In 1890, his wife, who had made his home life beautiful, died. In 1894 he was married to Mrs. Harriet B. Willard, of Keeseville, N. Y. About this time he moved to the Marlboro Street home, where he died. Three sons survive him—Harry, of Boston, Edmund K., of Lexington, and Silas A. Houghton, M. D., of Brookline.

His memory will be long and tenderly cherished in many homes and in many hearts. He was, in very truth, a "beloved physician." To a deeply affectionate and sympathetic nature he joined in large degree close and accurate observation and sound judgment. His lovable spirit and sterling character will make him long remembered by all who knew him. No one ever met him but recognized one of God's real noblemen. He loved and honored his profession and was devoted to his work. A veritable MacLure of Drumtochty, no ride was too long, no weather too severe, no home too humble, if so he could serve the sick and relieve suffering. When in late years it was suggested that he should leave "charity work" to younger and less busy men he

replied, "My service is at the disposal of any who need it and ask for it."

Modern schools may furnish fuller courses and ampler facilities than those of his time afforded. They will be fortunate indeed if they give to the community men as true and noble.

He has finished his work and entered upon his rest and reward. "Come, ye blessed of my Father; I was sick and ye visited me."

N. P. E.

EDWIN M. HALE, M. D.

Dr. E. M. Hale was elected Corresponding Member of the Massachusetts Homœopathic Medical Society in 1865. On Sunday, January 15, 1899, in his home at 2200 Prairie Avenue, Chicago, Ill., after a short illness from uremia, Dr. Hale died.

Dr. Hale was born at Newport, N. H., 1829. At fifteen he learned the trade of printing in Fredonia, Ohio, soon became assistant editor. He graduated from the Cleveland Homœopathic Medical College 1859, soon showed great ability in writing on Materia Medica subjects. This led to his being assistant editor of the N. A. Journal of Homœopathy and the American Observer. In 1864 he was elected to the chair of Materia Medica in the Hahnemann Medical College; occupying that chair eighteen years. Later on became professor of Materia Medica in the Chicago Homœopathic College, which he held five years. In 1876 went abroad and was received with great cordiality by the profession. Retired from practice in 1895 and settled in Orange Grove in Florida.

He was always a busy man, not only as a medical man but as a citizen. Has written many works on Materia Medica, also published a work on the "Practice of Medicine." He leaves a widow and two children, Dr. Albert Hale and Mrs. Frances Gardner. Dr. Albert Hale will edit a manuscript left by his father, on Old Age, and issue it in the near future.

DR. JOSEPH SIDNEY MITCHELL.

Chicago, Ill.

CORRESPONDING MEMBER OF THE MASS. HOMŒOPATHIC MEDICAL SOCIETY.

Death has been busy among us of late, and our ranks are thinning out. Within a few weeks Drs. Mitchell, N. W. Rand and J. Heber Smith have all passed away. The announcement of Dr. Mitchell's death will bring to very many in the Homœopathic profession a most

profound sadness. An earnest student, a searching investigator, a dispassionate reasoner, he was yet firm in his beliefs and brilliant in their advocacy. Strong in character and determined in purpose, he united with these excellent qualities a singular gentleness and kindness of soul that endeared him to all his associates and friends, as well as to the profession at large. His loss is not to the West alone. Such men as Mitchell live not to themselves alone, but for humanity, and when they join the great majority there is cause for common sorrow. Dr. Mitchell's death was sudden; he died as he lived, in the harness. He was Dean of the Chicago Homœopathic Medical College, and was the President of the World's Congress of Homœopathic Physicians and Surgeons in 1893. He was one of the prominent citizens of Chicago, and enjoyed the esteem and friendship of the best people of that city. The verses by Dr. Ch. Gatchell, which close this comment, will reach many a responsive chord in the memories of the multitude who knew and loved Dr. Mitchell.

JOSEPH SIDNEY MITCHELL.

O man of upright life, whose every act
Was pure! With thee a thousand hearts
Lie buried. Our faith, our love, were all
With thee, and in thy brave career
Thy comrades saw the promise bright
Of Hope's fruition. Thy colleagues
Mourn thy loss, and in their hearts thy memory dear
Is deep enshrined. And yet, to them,
Thou art not gone. Thy noble life
A thousand lives inspires to
Nobler deeds. The youth thou'st taught,
However poor, to strive
For honors high. Thou'st taught us all
The way to live, and taught us how to die.

— CH. GATCHELL.

REPORT OF THE COMMITTEE ON CLINICAL MEDICINE.

CHARLES R. HUNT, M. D., *Chairman.*

- I. Arsenicum Iod. vs. Tuberculosis, Carl Crisand, M. D.
Discussion opened by J. P. Rand, M. D.
- II. The use of Antidotes in Chronic Diseases. Maurice Worcester Turner, M. D.
Discussion opened by Conrad Wesselhoeft, M. D.
- III. Some points on Diabetes, James Krauss, M. D.
Discussion opened by Edward P. Colby, M. D.
- IV. Clinical Cases, F. A. Warner, M. D.
Discussion opened by G. Forrest Martin, M. D.

ARS. IOD. VS. TUBERCULOSIS.

BY CARL CRISAND, M. D., WORCESTER, MASS.

Of all the diseases to which human flesh is heir, there is probably not another one to which so much time and diligent study has been devoted and one in which the profession and laity are so deeply interested, as tuberculosis. And well may we devote much time and study to this disease for it annually claims many thousand precious lives from all over the world and brings much sorrow and long suffering to many homes, and its invasion and attack are as treacherous and stealthy as a snake in the grass. In its incipency, we can stay the disease, but when its relentless hand is firmly fixed upon the poor victim, his doom is sealed and no mortal power can stop its progress and restore the patient to perfect health and the enjoyment of life.

With these dismal facts staring us in the face, should we not hail with delight any and all remedies and means which, though only in a small degree sometimes, will relieve the suffering, cool the fevered brow, control the harassing cough, check the night sweats and, if the disease has not progressed too far, will kindle new hope in the heart, renew the strength of body and mind, give Nature a chance to assert herself and possibly assist her in throwing off the burden, beneath which she is groaning and of which, unaided, she could not rid herself.

There are many remedies and adjuvants which are very helpful in combating this disease, but of those which I have tried, *Ars. iod.* is the one which has given me the best results. Under its administra-

tion, some of my tuberculous patients have been cured, and therefore I have great confidence in the remedy. And when I make the honest confession that my faith in medicine is very limited and that I believe the *vis medicatrix naturae*, in company with proper feeding and hygienic surroundings, will accomplish more and greater cures than our long list of vaunted remedies, as, for example, at our Rutland Hospital, my listeners will, perhaps, give more credence to my words and will certainly not consider me a crank on *Ars. iod.* or any other remedy, and will I trust, be all the more interested in my experience with the remedy.

Some eight or ten years ago, my attention was called to this remedy, and since then I have watched its administration with careful interest. I have preserved the clinical records of twenty-eight cases, and the temperature charts of some of them, and have never failed to have the sputum examined by my friend, Dr. J. P. Rand, who is an expert at the business. Permit me to note, in passing, that all the cases, in whose sputum the tubercle bacilli were not found, have recovered. Of the seventeen cases in which bacilli were found, three are perfectly well today. One of these, a woman, has remained well for eight years; the second, a young man, has been in good health for two years, and the third, also a young man, has done well for three years. These three had pulmonary tuberculosis. Another patient in this list is a boy, now about twelve years old, whose right thumb I removed nine years ago on account of tubercular disease of the joint. He is not strong, but in fair health. Thus far there has been no re-appearance of tuberculosis in any part of the body. All of these four cases have a family history of tuberculosis. It is fair then, to state that of the seventeen cases, 23.5% remain cured up to the present time.

Let me say just a word about my mode of administering the Iodide of Arsenic. We all know that patients become tolerant of almost any drug, and acting upon this knowledge, I have begun with the fourth potency, giving from five to ten grains, three to five times daily and gradually worked up to the second potency; the frequency and size of the dose remaining the same. I would lay great stress upon the necessity of increasing the strength of the remedy as the system becomes accustomed to it, and then, after all signs of the disease have passed away, to decrease both the strength and frequency of the remedy and dose.

It is very interesting to notice how quickly some of my patients have responded to this remedy, even those in whom the disease was too far advanced to offer any possible hope of cure. This leads me to believe that in the early stages of tuberculosis even though there is an afternoon rise of temperature, *Ars. iod.* is very effective. All my patients who recovered gained rapidly in weight and are now heavier than ever before in their lives.

I have now under treatment, a young man, a hostler, who is taking about an ounce of *Ars. iod.* 2 x per week. When he came to me in January, his right lung was full of rales, there was considerable dyspnoea, thick tough greenish expectoration, languor, and appetite not very good. At present his lung is very clear, he takes a much deeper breath, can walk up hill better, and when I asked him for a specimen of sputum a week ago he said: "That stuff is getting scarce doctor." He looks well and strong and I expect his complete recovery, although Dr. Rand tells me that the sputum still contains quite a number of bacilli; some of them, however, show signs of disintegration, which is quite encouraging.

I want to mention another case which Dr. Rand and I treated at our dispensary three years ago and which we believed to be a form of lupus on the arm of a boy of about sixteen years of age. We tried various remedies and local applications but saw no marked results until we put him on *Ars. iod.* He did remarkably well and the wound healed over nicely. A month or six weeks ago, he came to the dispensary again, presenting a small swelling above the site of the old ulcer and also several purplish spots on the back of the hand of the same arm. I immediately put him on the *Ars. iod.* again. The small swelling on the arm is disappearing, the spots on the hand look less angry, and the tissues between the spots present a better and more healthy color. Granting that lupus and tuberculosis are one and the same disease, this case and that of the little boy whom I mentioned represent an interesting class in which the disease is localized and confined to a very small area. The boy with lupus looks and feels perfectly well and strong.

In the treatment of my patients, all available adjuvants were employed, such as rich, nourishing diet, emulsions, inhalations of pine oil vapor, physical exercise, deep breathing, plenty of fresh air night and day. An intercurrent remedy was occasionally given to control special symptoms. In the main, however, *Ars. iod.* has been my sheet anchor and has been used until satisfied that it was doing no good. My practice may be criticised by my strict Hahnemannian brother as being too empiric. Can he show better results? My patients were satisfied and so am I until I find something better.

DISCUSSION.

Dr. H. C. Clapp could agree with the writer that this remedy was a valuable one in this form of disease. He was inclined to think that Dr. Crisand was somewhat favored in his field of work as compared with some of the other towns in the State, as well as those on the sea-coast, due to the favorable situation of Worcester in its natural surroundings. The same remedy then might not be expected to accomplish as good results elsewhere. He used the

remedy more than any other, excepting perhaps, phosphorus and arsenicum. He assumed that he was not to understand that the doctor used this remedy with each case as it came along, as that would subvert the principle we all believed in, since it was as necessary to individualize in tuberculosis as in any other diseased condition. It was presented by the writer simply as a remedy giving the most favorable indications. In his own experience he had found the remedy especially valuable when the symptoms presented resembled those of each constituent of the compound. There were, of course, many other remedies which were serviceable in this disease, associated with hygienic measures, and the latter in his opinion were becoming more and more valuable each year of his experience.

Dr. Hiram L. Chase being called upon, said, that he had used the remedy but could add nothing to what had been said by the writer. His own use had been rather for chronic bronchitis than in tubercular troubles.

Dr. Crisand in reply to a question said that he used the drug in five grain doses, three to five times daily. Sometimes it was necessary to reduce the dose if the point of toleration was exceeded. He, of course, wanted it understood that he used other remedies when better indicated, or as he was able to individualize. His observation, however, led him to believe that it was an important and valuable remedy and acted better than any other remedy, on the average, even apparently well-indicated as the other might be. The examination of the sputa he considered an essential part of the examination of the case.

THE USE OF ANTIDOTES IN CHRONIC DISEASES.

BY MAURICE W. TURNER, M. D., BROOKLINE, MASS.

The usual way of beginning the treatment of a chronic case, which has been under allopathic care, is to antidote the various drugs that the patient has taken.

This is most commonly attempted by giving *Nux Vomica*.

Sometimes the result is all that can be desired, and a gradual restoration to health ensues, without the aid of other medicines.

But in many such cases *Nux Vomica* is not curative and certain questions then arise, as for example :

- 1st. How long to continue the exhibition of *Nux Vomica*? or
- 2d. What length of time to wait, after giving a number of doses, for the symptoms to readjust themselves, or in other words "for the case to clear up," before deciding upon a second remedy? And these queries suggest a

3d. Is it wise, or good practice, to give a general antidote in this routine way?

With the large proportion of failures, following this treatment, the answer seems plain. And, we may ask, why in chronic cases which have been drugged does not Nux Vomica affect one as well as another?

For an explanation of this want of success it is necessary to ascertain what Nux Vomica antidotes. In Hering we find the list as follows:

"It antidotes: narcotic, drastic and vegetable remedies; bad effects of aromatics in foods, such as ginger, pepper, and of so-called hot medicines; citrate of magnesia, coffee and alcoholic drinks; tremors of mercury, neuralgia of mezereum; ether."

This is helpful as it limits its sphere of usefulness. For example there is not much said about the metals.

Following out this suggestion I looked over my notes of chronic cases for a number of years and found two confirmations.

1st. That those cases in which Nux Vomica was given antidotally, and the patient did not improve, or the case did not clear up, were the ones in which something beside the drugs, in the list just read, had been taken, notably the metals, and mercury and iodide of potash in particular; and

2d. That those in which Nux Vomica was curative, were Nux Vomica cases, irrespective of the fact that there had been drugging with drastic remedies, etc. The latter, of course, might not be true every time.

Now turning to the antidotes for Mercury we find, after the long list of drugs, this statement: — "and, according to Guernsey, where there has been an overdosing, *all symptoms agreeing*, give Mercurius high."

While this is nothing new, as it was spoken of by Boenninghausen and also, I think, by Hahnemann himself, yet it has quite recently been advocated as the proper procedure in any case, entirely aside from the symptoms, where there is a history of the abuse of medicines.

Guernsey says, "*all symptoms agreeing*," and this seems to be the keynote, in the use of antidotes, under the circumstances referred to as well as in other prescriptions.

The fact that drugs have been taken in quantity is only one item in the list of symptoms of a given case, and unless other signs agree, i. e. call for Nux Vomica, it is useless to exhibit it expecting continued and permanent improvement as you will most certainly have to look elsewhere for a curative agent—to use the well-worn phrase—the prescription must be based upon the totality of the symptoms.

From among seven chronic cases treated in this way, i. e. by antidoting the effects of large quantities of medicine by small doses of the same drug, I have selected the following one because it is not only illustrative of the foregoing statements, but is also interesting on

account of its complicated history and its many peculiarities. It is as follows:

Miss —, Age 40, hospital nurse, slight figure, medium height, light brown hair, gray eyes.

August 21st, 1896, she came to me first and gave a family history, on both sides, of cancer, tuberculosis and rheumatism.

As late as 1882 or '83, her health was very good but about that time she was inoculated through a cut or abrasion on the finger from a syphilitic patient and for four years had a serious time with the primary and secondary symptoms.

She was treated, during this time, by eminent allopathic physicians in New York City and under their expert care was salivated with mercury and given iodide of potash in large doses.

In 1888 she had gall stone colic and a month later a severe gastric hemorrhage.

It was then decided that the condition was gastric ulcer, as the typical symptoms of pain, tenderness, vomiting and haematemesis were all present. Several hemorrhages have occurred since but none as bad as the first one.

Some thickening and cicatricial contraction about the pylorus resulted.

For this stomach trouble she has taken much nitrate of silver.

In 1894 she had a gastritis and following that appendicitis, and later another attack of gastritis.

The region of the appendix has remained sensitive and she has been urged to have the appendix removed, but this has not been done.

Early in January, 1896, there was an operation for hæmorrhoids and fissure of the anus.

Her menses began to be irregular eight years ago about the time the secondary syphilitic symptoms disappeared and they ceased in 1894, when the gastritis and appendicitis occurred.

There has been more or less myalgia since the stomach became affected.

She is now much emaciated, weighing only 107 pounds, but not very anæmic.

Lately she has been taking medicine for the bowels, with local treatment for the rectum, also tonics, etc. On this account, the over medication, she was given *Nux Vomica*.

August 23d, she reported the stomach pains a little better, otherwise no change. This slight improvement continued until

September 10th, when there were frequent stools containing much bright blood, thoroughly mixed with the feces, and some mucus.

The stool was brought on by the least movement; and there was

Great pain all through the abdomen and also in the back;

Abdominal tenderness was marked; also

Thirst;

Flatulence;

Nausea, but no vomiting; with a

Tongue coated white.

She now received *Phosphorus* with relief, so that by

September 14th, she was as well as before the hemorrhage, and by

November 27th, her weight was 131 pounds, a gain of 24 pounds from *August* 21st, and while better there were many of the old symptoms remaining, as abdominal tenderness, constipation, etc.

From this time the pain and soreness in the abdomen became prominent, with exacerbations.

The action of *Phosphorus* was now nil and the abdominal pains, etc., were relieved by *Belladonna*, *Bryonia* or *Sulphur* at different times. This state of things continued until

March 17th 1897, when her weight had dropped to 115 pounds. The conditions were now as follows:

Tongue swollen, pasty with indented edges, not coated;

Bad taste;

Offensive, sweetish, breath;

Only slight thirst;

Sensitiveness of the right side of the abdomen,

< in the iliac region, with

pain which extends down the right thigh,

a steady pain, not sharp;

Abdomen distended with soreness all throughout;

Is most uncomfortable lying on the right (painful) side; and

> lying on the left (painless) side; and also

Feels > bent forward;

She is chilly in a cool room; but also is

< from warmth;

Wakes at night finding herself bathed in sweat,

not cold nor offensive but profuse;

This, of course, was suggestive of a recurrence of the appendicular disturbance.

On going over the case thoroughly I found that *Mercurius* was indicated, of which you will remember she had taken much as an anti-syphilitic, and on comparing the early symptoms of the case with those just given it showed that it was a *Mercurius* case at the beginning.

The following comparison of the symptoms of the case with those of *Mercury* shows the applicability of that drug to the condition.

The symptoms, of course, are not those one expects to find in an acute disease, they are of a more obscure kind.

The table includes both the early and late symptoms, and the comparisons are principally from *Hering*, but also from *Boenninghausen*, the latter being indicated by a B.

CASE.

Depressed.
Time passes very slowly.
Memory very weak.

MERCURIUS.

MIND.

Mistrust; sadness. B.
Time seems to pass more slowly.
Memory weak; forgets everything.

INNER HEAD.

Headache, often wakes with it,
and it lasts all day.
> in middle of the day,
> in cool air,
< toward night.

Chronic cephalalgia $\times \times \times$; pressing
or stitching pains in the head,
< in forehead,
only during day.

OUTER HEAD.

Constant pain in occiput, running
down to shoulders.
Head feels too large.

Head feels heavy and swollen;
as if getting larger and larger.

SMELL AND NOSE.

Coryza, slight, constant, discharge thin and acrid.
Much sneezing.

Coryza, with much sneezing; fluent, corrosive; nostrils bleeding, scurfy; nose red, swollen, shining; < from damp weather; at night; from either cold or warm air.

TASTE AND TONGUE.

Constant bad, metallic taste.

Taste: sweetish; $\times \times \times$ bitter; putrid; metallic.

Tongue: swollen, pasty, indented edges, not coated.

Tongue swollen, flabby, takes imprint of teeth; dry and red.

INNER MOUTH.

Cankers; often after stomach pain; very sore to touch and contact of food.

After catarrhal or gastric fever, small round vesicles upon reddened mucous membrane of mouth.

Breath sweetish, offensive.

Syphilitic ulceration of mouth.
Odor from mouth: bad, fetid; disagreeable, sweetish.

THROAT.

Catarrh of pharynx and also of Eustachian tubes.
Constant sense of constriction and soreness.

Inflammation of throat, extending upwards into posterior nares and downwards into larynx.

APPETITE AND THIRST.

No appetite.
Very slight thirst.

Complete loss of appetite.
No thirst. B.

SCROBICULUM AND STOMACH.

Great fatigue in stomach from using arms.

Gnawing, exhausting pain.

Often bilious vomiting.

Faints easily especially from the stomach pain.

Burning pain, and sensitiveness of stomach.

Bilious vomiting. B.

Peculiar deathly faintness caused by pressure in epigastrium.

ABDOMEN.

Sensitiveness of right side of the abdomen, < in the iliac region with pain which extends down the right thigh; a steady pain, not sharp.

Abdomen distended with soreness all throughout.

Is most uncomfortable lying on the right (painful) side.

Great sensitiveness to pressure, even weight of clothes, and yet > from holding up abdomen.

Flatulence of stomach and bowels, belching >.

Painful, hard hot, and red swelling in ileo-caecal region, painful to touch.

Abdomen: greatly distended; tympanitic; painfully inflated; tense, hard, swollen and sensitive.

Intestines feel bruised when he lies on right side.

Intestines sore as if pressed, cannot sleep on right side.

Shaking sensation of bowels when walking, they feel relaxed, as if they had to be held up.

STOOL AND RECTUM.

Hæmorrhoids have returned, with bleeding.

Prolapsus recti with stool, often.

Sensitiveness of anal region when sitting.

Constipation: Stool hard, bullet-like, with frequent ineffectual urging and feeling of constant pressure in the rectum.

Ineffectual pressure to stool, with protruding hæmorrhoids, which are painfully sore.

Rectum prolapsed: looked dark and was very painful, etc.

Anus feels raw, chafed.

Constipation: Stool tenacious or crumbling, discharged only with violent straining; constant, ineffectual urging, < at night; blood with stool.

URINARY ORGANS.

Twenty-four hours average urine 28 to 30 ounces; no sediment, albumin, nor casts.

FEMALE SEXUAL ORGANS.

Amenorrhœa.

Amenorrhœa: with congestions and ebullitions.

HEART AND PULSE.

Palpitation with labored beat and suffocative sensation, then hot flashes with sweat and flushed face.

Pulse intermits, irregular.

Palpitation: with fear; < at night, on slightest exertion; with cough and blood expectoration.

Aching pain at apex of heart extending upwards towards base; cardiac oppression.

Pulse: ××× when slow it is weak and trembling, imperceptible, with warmth of body; irregular, generally full and fast with violent beating in arteries, at times weak, slow, tremulous.

NECK AND BACK.

Pain in right kidney region, < lying down.

Stitching pain in small of back ××× on being touched.

LOWER LIMBS.

Stiffness of joints, especially < after sitting.

Painful stiffness in limbs; < after sitting. B.

LIMBS IN GENERAL.

Numbness of all the limbs; may wake with it or it may come on in the day.

Numbness externally. B.

REST, POSITION, MOTION.

< lying on the right, (painful) side;

Unable to lie on right side, intestines feel bruised, etc.

< lying on right side. B.

> lying on the left (painless) side.

> lying on left side. B.

Feels > bent forward.

Must bend double; colic.

Must lie on back with thigh flexed; on account of swelling between umbilicus and right anterior inferior spine of ilium.

SLEEP.

Sleepy on going to bed but pain prevents sleep.

As soon as he went to bed in evening pains recommenced and banished sleep.

Abdominal pains < lying, prevent sleep.

Just after falling asleep pains become more violent.

Cannot sleep till 3 A. M., then sleeps the rest of the night, and is rested in the morning.

Falls asleep late; wakeful till 3 A. M. Sleepless at night; on account of anxiety, ebullitions and congestions; from itching; from seeing frightful faces; frequent waking.

Feels > after a short nap in the afternoon.

> after sleep. B.

TIME.

Always < in the forenoon till 11
or 12 o'clock.

TEMPERATURE AND WEATHER.

Is chilly in a cool room and also < from warmth. Cold: cannot bear it. From warmth in general, or warmth of bed, syphilitic pains <.

FEVER.

Wakes at night finding herself bathed in sweat, not cold nor offensive but profuse. Sweat: ××× more at night; in evening in bed, falls asleep while perspiring; profuse and very debilitating at night, ××× profuse; ××× soaking through bed clothes; etc.

TISSUES.

Has lost much flesh. Emaciation. B.

SKIN.

Frequent attacks of urticaria with much itching, which is gradually relieved by scratching. Comes on especially when gets warm. Intolerable itching all over body, assuming appearance of nettle rash. Itching that becomes pleasant on scratching. < near the salt water. Itching all over body, especially at night in bed when getting warm. Itching so intolerable it almost sets him crazy if he gets a little warmer than usual when at work; when he first gets into bed, the cool sheets feel so nice he goes right to sleep, but after sleeping about half an hour, he is awakened by itching and has to get out of bed and walk the floor until the sheets get cool again.

After a few doses of *Mercurius* the symptoms steadily improved, so that on

November 4th, she reported that while there was still at times a constricted sensation in the region of the appendix, yet the mental condition was better, the bowels regular, etc., though the menses had not returned. I did not hear from her again until

March 13th, 1898, when she had a bad bronchitis, and in April following a slight return of the right iliac pain and tenderness, which rapidly yielded once more to *Mercurius*.

To the present time, as far as I know, she has remained well.

The conclusions suggested to me by this and my other similar cases, in which the results have been equally gratifying, are

1st. That the condition was clearly a poisoning by Mercury. After the syphilis was displaced by the mercurial disease there arose a sequence of complaints, or perhaps I should say a series of diseases, in which we often find *Mercurius curative*. Briefly enumerated they were, — Amenorrhœa; Gall Stone Colic; *Hæmatemesis*; (Gastric Ulcer); Gastritis; Appendicitis, *Hæmorrhoids*; Anal Fissure; Myalgia; are marked in the pathogenesis of Mercury while others have not been so well brought out in the provings.

It is impossible to estimate, in this case, how much the hereditary influences had to do with these developments.

2d. In commencing the treatment of a chronic case is it not wise, if there has been previously overdosing, to give a general antidote? With the exercise of greater care and the expenditure of more time, it will be found that a particular one is indicated; and

3rd. That a drug in alternation will antidote its crude effects, provided that the symptoms present are those which were developed in its proving; or, as Guernsey expresses it, "all symptoms agreeing."

DISCUSSION.

Dr. Conrad Wesselhoeft said that he had listened with pleasure to the reading of the paper, and had enjoyed a personal perusal of it. He wished that we might have more papers on this line, giving a careful analysis of the patient's symptoms, and not only stating the name of the disease, but going into the different phases of it. It might seem a little dry to the hearer, but it was, in his opinion, very nearly the right way to present the matter, especially in cases of chronic diseases. He wanted to say a word about antidoting medicines. In our older repertories, especially that of Jahr, the best one written, is given a list of medicines which are considered homeopathic antidotes picked out according to their symptomatology, and also a list of such medicines as are considered antagonistic, or likely to aggravate the case. He regarded these more as details than as a rule of actual value, although the suggestion involved was usually a good one. As far as an antidote to medicine was concerned it seemed to him that it was not well to have a general rule for the antidoting of the effects of medicines except when we could be certain the effects were those of a medicine recently administered. In active cases of poisoning we had learned by experience the exact antidote to give, as for instance, permanganate of potash for opium poisoning, or belladonna for the same, or oxide of iron for arsenical poisoning, etc., and he might add iodide of potassium for the overdosing by mercury in cases of syphilis. In these cases we have a positive rule based on positive experience, and medicines can be given in this way. He thought we ought to

Bear well in mind the antidotes for the not infrequent accidents of poisoning, or have them where we can refer promptly to them, as delay in treatment was often a serious matter and might mean a loss of life. But in chronic medicinal poisoning the case is different, for it might have been the right remedy but too much was given, or the wrong remedy in an overdosing quantity. How erroneously the patient's symptoms can be attributed to the medicine used, the paper gave an interesting example. No ironclad keynote should be applied in these cases. If we know the medicinal substance the patient has had in overdose, either by his own use or the advice of a physician, it is not a case of poisoning, for the medicine has probably been eliminated from the body, although the effects may have become chronic, and are troublesome. In such cases the best course to pursue was to go to work symptomatically, entirely regardless of the medicine which we may think the exciting cause of the trouble, prescribing for the symptoms as we find them, without much regard to the medicinal cause of the poisoning. In the case related the doctor may have known, or may not have known, that Mercury had been used, but the symptoms told the story. It was very likely that there was neither Mercury nor syphilis in the patient at that time, but the symptoms pointed only in one direction. No matter if we knew the medicine which had been given in any case, it might still be the homœopathic remedy in a higher attenuation. It was very hard to be positive about these things, although we all knew that one was often considered an authority from the positive way of expressing an opinion. He thought it was the best, however, to qualify the statement as he had, namely, that a higher dilution of the medicine supposed to have caused the trouble in a case under observation, may prove to be the curative remedy. He thought the question should be considered to be still sub judice, no matter if a positive statement had been made by others. He certainly had seen benefit in cases of rhus poisoning, in the use of the remedy in a higher dilution.

SOME POINTS ON DIABETES.

BY JAMES KRAUSS, M. D., BOSTON, MASS.

The purpose of this paper is not to dwell upon the different phases of diabetes, the various methods of diagnosis, the many modes of treatment, but to draw attention to a few points of practical importance that have suggested themselves by the following case.

On Sunday evening, December 11, 1898. J. W. U., a young man of about twenty-four, consulted me for what he termed was nothing but a cold. It was the time of the gripe. For the three preceding weeks

he had been ailing, and as he could not shake off his indisposition he desired professional advice. He was studying in the Burdett Business College and wished to resume his work as a student the next morning.

The patient had the appearance of a tall, lank youth, somewhat short of breath. The thermometer registered 102° F, and the stethoscope gave evidence of hepatization of the lower lobe of the right lung.

By this time my consulting room became penetrated by a sickening sweetish odor, the sweet apple odor of acetone. I asked the patient to pass urine. The urine was pale, quickly tending to become turbid, and contained 5% of a substance that reduced cupric oxide and that on further examination was positively identified as glucose. On applying Gerhard's test of a solution of ferric chloride the bordeaux red color of diacetic acid left no doubt that the case was one of the most serious nature.

But it was almost impossible to convince the patient and his friends of the impending danger, and only reluctantly would he consent to keep his bed. When I called the next morning he said his cold was so much better that he thought he ought to be allowed to go to his college; and in this, I learned later, he was supported by some of his friends, adherents of Christian Science, who exhibited their fidelity to their belief by permitting the patient to leave his bed for the performance of necessary functions, contrary to my instruction. I insisted on installing a trained nurse, as the dyspnoea, in spite of his protestations, had increased. I made a distinct statement to the friends that the patient might die almost at any time, and that my instructions must be carried out to the letter, that the nurse must not be hampered in any way. Towards night the dyspnoea increased and the urination, according to the notes made by the nurse, had decreased in frequency, and, what was more, the urine had decreased in quantity. At midnight I was roused from bed because the patient was unconscious. I found him lying on his back, inert, the extremities cold, the pupils dilated, reacting only to light, and the color of the face, fair and lively before, had changed to an almost indescribable pallor. It was not the waxy pallor of parenchymatous nephritis, it was not the bloodless pallor of leucæmia, but a pallor giving the shade of a stiff mixture of white and yellow which must be seen in order to be appreciated. Five hours later, altogether thirty-three hours after coming under observation, the patient was dead.

The fearful rapidity with which this patient passed from a state of apparent health into a state of fatal coma, must be recognized as not at all uncommon in diabetes. Diabetes is a dangerous disease in itself, but becomes much more dangerous when a complication of another disease, especially one of an inflammatory nature sets in. It makes no difference whether such inflammation is the result of glucose irritation or of the accumulation of acetone in the blood, whether it is

an expression of the acid intoxication of the system, or, as I viewed the pneumonia of my patient, the result of cold, the complicating disease is in almost all cases a warning signal of an impending fatal issue. We have the word of no less a man than Bouchardat who, in speaking of lobar pneumonia as complicating diabetes, declares that the pneumonic process is distinguished only by its extraordinary gravity and a rapidity of almost lightning-like progress. This I believe can be readily understood when it is recalled that a diabetic patient carrying in his blood an amount of glucose wholly out of proportion to that obtained in normal digestion, suffers from impeded circulation. His temperature is usually subnormal, and the high temperature of acute inflammations is wanting. My patient's temperature of 102° must be taken as the equivalent of 105° or 106° in an otherwise healthy subject. It is not at all uncommon for acute abscesses to occur in diabetic patients with a temperature of normal degree. A laggard circulation of blood must soon arrive at a point of stagnation when additional demands are made upon it, and the demands coming from an acute inflammatory process are imperative. Thus the road is prepared for the appearance of diabetic coma, the final stage of most cases of diabetes.

The practical significance of diabetic coma, it appears to me, lies in the recognition of this fact that coma forms the final stage in the natural history of diabetes. Most patients of diabetes die from diabetic coma. Those that do not, die, as regards diabetes, a premature death. Pavy declared that while tuberculosis, and by this I think, he must have meant the emaciation and exhaustion suggestive of tuberculosis, forms the natural end of untreated, that is, neglected diabetes, the end of diabetes when treated, is acetonæmia, a term that best expresses, to my mind, the underlying pathological state of diabetic coma. In this light, the condition of diabetic coma assumes a degree of practical importance which cannot be too highly placed. It is possible that hypodermoclysis or other vaunted measures may for the moment change the picture of coma and give another respite to the patient's life, but on the whole, the appearance of diabetic coma means the beginning of the end. Yet this beginning of the end should not be allowed to appear before the disease has run its natural course.

When treatment is begun for a patient suffering from diabetes this point must be kept constantly in view. No greater mistake can be made than to follow an expectant mode of treatment, for with it the door is left open for neglect, for complicating diseases, for all the causes of premature diabetic coma. This has been plainly shown in the case of my patient. On inquiry he informed me that he had been under treatment for diabetes from time to time, but as he felt well he stopped treatment the preceding August, that is, four months before his death. Had the patient been duly impressed with the

necessity for continuous active treatment, it is not unnatural for us to suppose that his death might have been deferred for at least a year.

Active treatment should be begun as soon as the presence of diabetes is discovered. The pity of it is, however, that the disease is seldom discovered at a very early stage. Every practitioner recognizes diabetes when it is fully developed, when the patient presents the symptoms of polyuria, polydipsia, and polyphagia. Everybody can also analyze the urine and find sugar when present. But these symptoms mark already an advanced stage. Specialists, therefore, often recognize diabetes before a general practitioner will ever suspect it. The dentist recognizes it by the presence of gingivitis; the dermatologist by eczematous eruptions, xanthoma, and general pruritus; the ophthalmologist by certain forms of amblyopia and cataract; the genito-urinary surgeon by vulvar pruritus and balanoposthitis. Is there no symptom which should rouse equally the suspicion of the general practitioner?

Diabetes in its incipency, is a somewhat elusive disease because it hardly ever gives rise to pain, it never heightens the temperature, it never causes chill, and not always does it start a crop of boils or carbuncles. But though insidious in its onset yet I have observed that it makes a distinct impression early upon the system, and this impression is shown in an otherwise inexplicable appearance of sexual debility in man and sexual repugnance in woman. When a man becomes sexually impotent, and a woman with a formerly healthy sexual appetite becomes indifferent it is always a sign of some constitutional derangement and calls for immediate and thorough examination of the urine. I believe the sexual function is the thermometer by which we can measure the approach of diabetes.

Various theories have from time to time been proposed to solve the nature of diabetes and give a clue to treatment. But none has gone beyond the fact that diabetes is a disease of defective nutrition; and no treatment that does not place the regulation of the food and drink at the front deserves to be noticed. All medicaments that have ever been applied in this disease by whatever method of therapeutics have received their value only by the simultaneous dietetic treatment.

We have been told until we have come to believe it as one of the fixed rules of therapeutics that by proper diet and hygiene the life of diabetic patients may be prolonged for fifteen, twenty and thirty years. Yet this statement applies only to a certain class of cases. Those that are corpulent and retain their corpulency may, indeed live; but those that are deficient in flesh usually die a speedy death.

This explains to my mind, why diabetes is so much more dangerous in the young than in those who have already stepped into middle age. I have never known a patient who became subject to diabetes in his youth live beyond his twenty-fifth year. My personal experience extends only to ten cases, three of which were youthful subjects. All

three died in their twenty-fifth year. I cannot place my hand upon any authority who makes this distinct statement; although all say that the younger the patient the graver is the disease. In the search of literature I fail to find a case of diabetes in youthful persons to have passed the twenty-fifth year limit. Why should this be?

It may be possible that the pancreatic origin of the disease accounts for this fatal fact in the young. But I hardly can credit it that the young should be so much more often subject to pancreatic diabetes than the old. Lancereaux gives it that in the old and corpulent, diabetes is a disease of nutrition, while in the young and lean, it is a disease of digestion. But to my mind it is much more rational to suppose that the reason for this difference in the prognosis between the young and the middle-aged diabetics lies in the fact of corpulency in the one and non-corpulency in the other. We know that the tendency of diabetes is to emaciation, and if the person, as it is the case in the young and undeveloped, does not have much resistance to offer to the emaciating process, the fatal course of the disease cannot long be hindered. If I have ventured to propose this theory it is simply because I see in it the most practical lesson for the treatment of all diabetics. It is to keep the body in its usual weight and rotundity.

DISCUSSION.

Dr. E. P. Colby regretted that he had not had a chance to read the paper in advance, nor was he able to tell from the title in what direction the discussion was to be carried on. He had perhaps very little to add which could not be found in any text-book or in the paper. He would say a word in regard to the point advanced that sexual weakness was an index of importance in this condition. This would be a valuable index to follow if one could believe it, for he could not accept this as a guide in diagnosis. It had been his custom for years to carefully examine the urine in all neurotic cases coming to him, and he probably had as many cases of sexual perversion or lack of power coming under his observation as the average practitioner, for treatment or diagnosis. He could only remember two or three cases where sugar was present, and yet nearly every case had loss of sexual power. With the exception of a few cases of organic cord disease or the early stages of tuberculosis, you will find that these conditions will produce this loss of function or hold it in abeyance. He should hardly want to accept this index in the light of this experience. The urine should be carefully examined in nearly every case coming to us, for its indications are valuable. The case reported in the paper was a remarkably rapid one. Here was an instance where we could see the results of a case developed from an attack of pneumonia. Diabetic blood seems to form a good culture medium for the pneumococcus, and prone to the development of pneumonia, either from

that cause or because the nerve centers are weakened. The diabetic pneumococcus in the blood led him to rather suspect a metastasis of the pneumonia to the cerebral centers, with possibly the production of a sinus thrombosis, which would account for many of the symptoms in this case. Patients do die of coma in a large percentage of cases of diabetes. To keep the patient well nourished with the carbohydrates was very important. He had under treatment last summer a patient with a tendency in this direction, in whom there was a sudden and rapid development of somnolency, and other threatening symptoms and the case was seemingly going rapidly to the bad. The recovery, however, was remarkable and satisfactory. In substantiation of the theory advanced by the writer he would say that this patient was very corpulent.

Dr. A. M. Cushing reported briefly a case he had lately seen of this condition, a typical case of polyuria, with specific gravity of 1030, and 3 per cent. of sugar, with loss of sexual power. On account of the latter marked symptom he gave him argentum nitricum 200, and also pills of Phaseolus. An examination within a few days showed an increase of sexual power, sp. gr. 1022 and the sugar reduced to one and one-half per cent.

Dr. Krauss expressed regret that he had not been able to finish his paper to give to Dr. Colby before the meeting. He thought he had misunderstood his reference to loss of sexual power, that it was always seen in diabetics. What he had said was that it was a sign of constitutional derangement and called for a careful examination of the urine. He did not refer to cases of sexual perversion or cases of debility, but he believed that in the examination of these cases, the first expression of any such trouble would be found here.

CLINICAL CASES.

BY FRED'K A. WARNER, M. D., LOWELL, MASS.

CILIARY NEURALGIA — BRY.

Mrs. H., aged 50. Dark hair and bilious nervous temperament. Has been subject for years to occasional attacks of pain over the right brow and in the right eye. The eye could not be moved without a severe paroxysm of pain. Opening the eye would aggravate all her suffering. It often extended to the malar bone or deep into the brain. At other times it was located at the angle of upper and lower jaw and then the pains would be aggravated exceedingly by talking,

swallowing liquids, masticating and swallowing food ; even using the arms would bring a return of all her suffering. The history of every attack seemed to point to fatigue and exposure to cold air as factors in bringing on the attack. The tongue was white and mouth very dry. It will be noticed that aggravations were caused by opening the eyes, motion of the eye-ball, motion in general, speaking, eating, touch, least exertion, using or moving eyes. Ameliorations were by external pressure, lying on the affected side, and cold applications.

We have then in the above symptoms a complete picture of bryonia, and its sequel proved that it was a perfect similar. I wish to make this remark. I found that if I gave Bryonia 3 x that it would produce an aggravation if repeated every two hours, and then I was obliged to stop the remedy. Later on the pain would abate, and the patient was soon well enough to be discharged.

After visiting the patient during repeated attacks, I learned to administer but one dose of Bry. 6 x, and when I came the next day, instead of the aggravation the patient was convalescent and comfortable. At the last attack Bry. 30 one dose was given, and convalescence quickly established, so that I was able to dismiss my patient, on second visit. Almost two years have passed without an attack.

Miss X, aged ten years, came to my office with a large swollen gland under the left ear and extending from the mastoid region almost to the clavicle. It was hard as bone, attended with more or less lameness and dull pain. Her hands were damp and cold as well as her feet. When a babe, perspiration was found on the pillow after sleep. Mentally she was rather irritable.

Calcareo Ostrearum, 500 was selected and repeated every 7th day. At the end of three weeks the enlargement was decidedly less and diminishing day by day. Previous to this attack, in fact always, her complexion was especially white and pale. When convalescence was fully established the skin assumed a pink hue, and this hue has been maintained for four years.

I have seen Sulphur produce the same result in the complexion when treating itching humors. One case in particular. Young lady twenty-five years old, very pale, would not tan or burn at the sea shore, even after three months residence. She came to me for treatment of an itching humor. Sulph. 500 proved to be her remedy, curing her humor and giving her a fine rosy complexion.

Case 4. Mrs. K., aged 48, had violent attack of Lagrippe, aching all over, head, spine and limbs. Headache began in back of head and extended over to the eyes. Said I would have to give her morphine, as she had always had to take it for such headaches. I gave her Gelsemium which relieved her head. The disease extended to the chest involving the bronchi, more on the left than right side, with sharp tearing pains when coughing. Bry. 6th was given and followed by an abatement of bronchial symptoms. When first taken I noticed

an objective symptom, i. e. that she constantly wore a light woollen shawl around her head and neck, and upon inquiry found that she was inseparable from this shawl when in bed. This objective symptom hinted at the disease and the remedy, viz.: Asthma and Arsenicum. I found that she was subject to asthmatic attacks when a young lady; so I was not surprised when the patient could not lie in bed, but had to sit up in a chair and in a very erect position of the body. This position was continued day and night for nearly ten days before she could recline for even the shortest time. The bronchitis seemed to be influenced by the asthmatic habit. When the bronchial symptoms abated Bryonia was omitted, Arsenicum 6th was given every morning for several days and then omitted. Finally the patient was able to lie down in bed for an hour; next night, two hours, and so on until nine hours. Arsenicum 200th was given to terminate the treatment, one dose only. During two months after the patient was dismissed, she had ceased to wear any wrap about her head when in bed. Furthermore, at this present time she claims that her spine and head have not been so comfortable for years.

The outcome of this case of Lagrippe complicated with an asthmatic habit and continuous spinal irritation for years teaches us at least not to be discouraged.

DYSPEPSIA — CAL. O.

Case 5. Mrs. B., aged 42, had been suffering more or less from gastric disturbances during two or three years. The results of treatment by skilful prescribers were unsatisfactory. While taking the case I learned that she menstruated every three weeks, and that flowing was profuse. Believing as I do that a woman who menstruates every twenty-one days is almost sure to be ill two-thirds of the time from the pelvic disturbances, and that the stomach is very likely to become involved, I ignored the gastric symptoms and sought for a remedy that would be likely to extend the menstrual period to its normal time.

Guided by the general symptoms of the case my choice was directed to Calcarea Ostrearum, 500, and under its deep acting and subtle influence during the following three months, the time of menstruation was extended to twenty-seven or eight days with normal flowing. The stomach meanwhile came to be an organ that the patient was utterly unconscious of.

REPORT OF THE COMMITTEE ON DISEASES OF CHILDREN.

NELSON M. WOOD, M. D., *Chairman.*

- I. Ilio-Colitis, Etiology and Pathology, Frank A. Gardner, M. D.
Discussion opened by Kate G. Mudge, M. D.
- II. Ilio-Colitis, Symptomatology and Diagnosis, D. W. Vander Burgh, M. D. Discussion opened by Eugenie M. Phillips, M. D.
- III. Ilio-Colitis, treatment, Geo. H. Wilkins, M. D.
Discussion opened by Nelson M. Wood, M. D.
- IV. Cholera Infantum, Pathology and treatment, Frank A. Hodgdon, M. D. Discussion opened by Carroll C. Burpee, M. D.

ILIO-COLITIS.

BY D. W. VAN DER BURGH, M. D., FALL RIVER.

Ilio-colitis is both acute and chronic. The acute form is usually ushered in with slight chilliness, or a chill-malaise for a few days preceding the attack, diarrhœa, with some fecal matter in the first few stools, followed by watery movements with more or less mucus, accompanied by colicky pains. The face early shows the effect of the disease; the drawn look caused by exhaustion and crampy pains, the sunken eyes, the Hippocratic expression and clammy sweat which sometimes appear before death, only emphasize Nature in her last struggle for life.

The tongue is coated with a thin, whitish fur, but later on may become raw on the edges or dry and shiny all over. Thirst soon manifests itself, and when the stomach is also involved with the upper bowel, water may be thrown up as fast as swallowed. The appetite is usually diminished or lost, though when the lower bowel is mostly affected there may be desire for food, and in the later stages the ravenous appetite of starvation.

Nausea and vomiting are more frequent as a rule when the disease is centered high up in the canal than when lower down, in which case one is more likely to have tenesmus. Tenderness more or less is apt to be felt over the abdomen, especially along the course of the colon. Tympanitis is likely to occur later on. The number of stools varies with the intensity of the disease, but generally there will be from four to eight in twenty-four hours. The character of stools varies from watery and fecal to mucous and bloody.

The color of the stools changes from light yellow, dark green, and brown to tarry blackness; blood which passes may be from the efforts to evacuate as well as from the intense hyperæmia of the canal.

The sour smell which is often present, both in the breath and stool, is an indication of fermentation in the bowels, frequently the original cause of the disease.

In ordinary cases there is fever in the beginning, but it is likely to subside. It is not characteristic unless it be associated with typhoid fever or tuberculosis. Any later accession of fever would point to further complications or extension of the disease.

Pain is quite a common symptom, *gripping* and *colicky*, about the umbilicus, the sides of the abdomen, and along the course of the colon. *Paroxysms* of pain usually precede, and are relieved by evacuation of stool.

There may be restlessness, sleeplessness, delirium, jactitation of muscles, convulsions, and conditions of reflex irritation such as would lead one to suspect absolute organic disease of the brain.

The symptoms of chronic ilio-colitis are more or less those of the acute. The activity is less, in most cases, but the danger is greater. The conditions and character of the stool are somewhat different; there may be a constipated condition in the upper part of the canal with a catarrh below.

The dejections may be of a fibrinous nature in the form of casts and ribbons, especially in the diphtheritic type, or where extensive sloughing of mucous surfaces is present.

The diseases that one would be likely to confuse with ilio-colitis are cholera infantum, typhoid fever and diphtheria. One would distinguish it from cholera infantum by the peculiar dejections, the persistent vomiting, and the intensity of the latter disease. The only definite thing to distinguish it from typhoid would be the discovery of the typhoid bacillus, though the characteristic eruption and the thermometrical waves, together with the greater tenderness over the region of Peyer's glands, would assist in the differential diagnosis. From diphtheria one would discriminate it by the general milder form of attack, the throat symptoms, and the glandular swellings, as well as by what the microscope might reveal. The membranous discharges and pus would distinguish an acute from a chronic attack, but would not a diphtheritic from a tubercular variety. Here again one must depend upon the microscope.

In some cases of measles and whooping cough, a condition obtains which renders necessary caution and close attention to the history of the case to prevent an error in etiology.

TREATMENT OF ILIO-COLITIS.

BY G. H. WILKINS, M. D., PALMER, MASS.

Before considering the matter of treatment we may well give a moment's thought to prophylaxis. We are beginning to realize that most of the diseases of the digestive tract, which we have been wont to attribute to an all-wise Providence are preventable, and due to our own stupidity or neglect. It has been said that "every child has a right to be well born." Fresh air, sunshine and repose should also be a part of his birthright. There are two other factors in normal development to which every child should have an inalienable right ; these are proper clothing and proper food. I think it is well for children to wear an abdominal band of flannel pinned moderately tight ; the rest of the clothing should be loose, giving freedom of motion, and in warmth adapted to the temperature of the room. Small babes should be kept very warm, but of children one year old and upward probably more suffer from too much clothing than from too little.

As preventing the disease now under consideration proper food is of still greater importance. If the mother be well she should furnish her babe in early life, with the diet intended by Nature. If this be denied, there is probably no substitute as good as modified cow's milk, Pasteurized.

The character and quantity of food and time of feeding should receive the careful study of the physician and be adapted to each individual case.

The treatment of Ilio-Colitis should be hygienic, dietetic and medicinal. The environment should be made as salutary as possible. Pure fresh air is a necessity, and if the patient can have out door air in the country so much the better. Perfect rest and quietude are also essential, and more readily secured in the country than in the city. Carriage riding is one of the best anodynes for nervous restlessness accompanying this disease, and the carriage motion, unlike bodily exertion exerts a quieting influence over the increased peristaltis, helping also to restore the normal tone to the intestine.

We have seen children, weak, nervous and fretful, cease their moaning and drop into quiet sleep when taken from the crib for a ride with horse and carriage.

Cleanliness is of course, required, but bathing should be done very gently, and with as little disturbance to the patient as possible, using warm water unless the child's temperature is considerably elevated, and cold water if the fever is high, always watching the effect most carefully.

Clothing should be loose and preferably of flannel, particularly that about the abdomen. The food supply is of the utmost importance.

As improper food and overfeeding have much to do with the etiology of the disease, so are they important factors in perpetuating it. Digestive action is practically suspended during the early stages of the disease ; and food had better be withheld, at least for a period of twelve to twenty-four hours, or until vomiting ceases. The child is likely to be very thirsty and small quantities of boiled water, rice water or barley water may be given. I have found the white of an egg added to one ounce of boiled water will often be retained when clear water will be rejected. If the child be nursing we should inquire carefully into the condition of the mother, and if necessary substitute a wet nurse or resort to artificial feeding, at least for a while. But it is with "bottle babies" that we are most likely to have trouble, and I think it is the common experience of physicians that a food which is suited to one case may utterly fail in the next.

Cow's milk should be withheld until acute symptoms have subsided. Even when Pasteurized and peptonized it seems to be unsuited to the early stages of this disease. Freshly made beef, mutton, or chicken tea, free from fat ; or white of egg solution may be given at intervals of two to four hours ; while barley or rice water and sometimes a small amount of well diluted cream may be given more frequently. If the prostration be great and the pulse becomes feeble, ten to twenty drops of diluted whiskey or old brandy may be given as a necessity and the bowels well flushed with normal saline solution. Care must always be taken not to overload the stomach, but during convalescence there is danger that too little food will be taken unless we take special care and unless we know definitely the amount ingested.

The various artificial foods have an important place in the treatment of this disease ; especially after acute symptoms have subsided. Every physician has his favorite foods, but we often have to try several in order to find the one best suited to the individual case. I think that we often give too little water in our cases of intestinal disorder. The child would not crave it so intensely if Nature did not demand it, and while judgment should be exercised in this as in other particulars there is more danger that we err by giving too little than by giving too much water.

In the use of drugs, there is scarcely any disease in which the Homœopathist has such a decided advantage over his brethren of the "old school." They frankly admit that after the dose of castor oil to clear out the alimentary tract, and the dose of Bismuth to disinfect it and the dose of Opium (seldom forgotten) to allay the irritation, there is little left to be done, and that cases actually improve faster without medicine than with it. Happily we are not thus limited. But the student is often less puzzled to know what to give than what not. And after he has consulted Allen, Bell, Lillienthal, Farrington and Cowperthwait he is inclined to cry out with the man to whom triplets

were born, "O Lord hold on with thy blessings." I will not attempt to enumerate the remedies applicable to this disease nor to give their indications. I believe in selecting the remedy for the individual case, but I usually find myself selecting from the following few remedies: Aconite, Aethusa, Arsenicum, Belladonna, Chamomilla, Croton tig., Merc. cor., Veratrum alb., and one other that I use perhaps more often any of these, namely, Arseniate of Copper.

If the stools be frequent, watery and perhaps tinged with blood, and if there be much abdominal pain, I fine Arseniate of Copper to be not only one of the best indicated remedies, Homœopathically, but also the most effective.

DISCUSSION.

Dr. N. M. Wood had one or two points to refer to in connection with the paper. One was the matter of acute cold due to unusual or careless exposure on the part of the mother, and in such cases he thought one of the most important things was to clear the tract of all irritating substances. This done it was better to withhold all food for twelve to fifteen hours, and then not to give milk or the usual prepared foods, for he had learned through long experiment in the years past that the best plan was to give expressed beef juice or Reed and Carnrick's Trophonine. This was retained better than any class of food he knew of. It was also serviceable in cerebral conditions with reflex vomiting. Following the above he was in the habit of giving cow's milk modified with peptogenic powder. He did not think there was any food equal to cow's milk or cream and water, with the curds broken up with the peptogenic powder. This did not peptonize the milk, if we wanted this we must boil longer and add sugar. After the acute symptoms have subsided, gradually and carefully add the food which is to follow, and with him these were along the line of gelatine mixtures. The rectal enemata were of advantage in these cases. They were to be used at blood temperature and freely, anywhere from two to six quarts, one teaspoonful of salt to a pint of water. Had used it with effect in many cases where there was griping pains, mucous stools, bloody and greenish. He elevated the buttocks and used long soft rubber catheter, thoroughly oiled, introducing it very carefully, allowing the water to run gradually while introducing the catheter, continuing the current until the parts are distended, then have it retained as long as possible. It pours out easily and gives prompt relief. The amount taken is much larger than we would expect. He usually followed the large injection by a smaller one of warm boiled water, about one pint, with a small quantity of witch-hazel, throwing it high up, and having it retained as long as possible. As to remedies these were more often belladonna, arsenite of copper, and merc. cor., than any others, and along this line of treatment most of his cases had recovered satisfactorily.

Dr. Moore inquired why the writer advocated the abdominal swath to protect the bowels, rather than the chest swath to protect the lungs? He thought that nearly every one now advocated that the surface of the body should be equally covered, rather than one part.

Dr. Wilkins said that the abdominal organs were especially liable at a season when lighter clothing was worn over the body in general. He perhaps could not say exactly why he used it, but certainly thought that flannel rendered good service. There was no doubt that many children were dressed too warm. He remembered one case in the hottest spell of mid-summer, with three flannel skirts on, and the feet tucked up so that the child could not move, it was simply roasting. He had the greatest difficulty in persuading the mother to reduce the clothing. Moderately cool extremities, and moderately warm abdomen, seemed a good working rule.

Dr. B. P. Barstow thought it was difficult to quiet many of these patients with the usual remedies, and in his experience this rest was absolutely essential to the cure. For this purpose he was in the habit of using the bromide of lime or potash, in doses sufficient to produce the desired effect, whether in the first decimal or in larger dosage. The bromides will give the patient nerve rest and from that time your patient goes on to recovery.

CHOLERA INFANTUM, ITS PATHOLOGY AND TREATMENT.

BY FRANK A. HODGDON, M. D., MALDEN, MASS.

During the thirteen years that I have been in the practice of medicine it has been my privilege to make and be present at ten autopsies upon children who have died of so-called cholera infantum.

To those who may have been an eye witness to this most fatal malady among our little ones, no picture need be painted, or word spoken, to portray one of the saddest sights that a physician is ever called upon to witness.

The pathology and treatment of cholera infantum is the province of this paper.

The pathology I will divide for convenience into two classes; namely, positive and negative, those which show pathological changes, and those which do not.

There is a class of cases in true cholera infantum that is taken so suddenly and dies so quickly that we have been unable to locate a single lesion upon the organs affected. I suppose this is due to the fact that a highly irritating organic poison, introduced generally by infected milk, is at work as much at the nerve centers, debilitating the whole system, as upon any special part of the system. In three cases of which I have record, where the patient died within forty-eight hours of the first symptoms of the disease, there was no reddened or congested condition of the mucous tract, the stomach was not inflamed, no catarrhal condition was found in any portion of the intestine, the colon was normal in appearance ; if any change could be observed it was that the mucous tract was rather paler than normal.

On the other hand, the cases which have pathological changes are more prolonged, and we get in the alimentary tract the following conditions.

Perhaps not all the changes were found in any one case, but in the aggregate we observed the following : mild inflammation of the gastro-enteric tract ; the mucous membrane was reddened, thickened and softened, not uniformly, but in patches.

The intestinal glands, Peyer's and the solitary, were enlarged and stood above the surface ; a few of these glands were broken down, and ulceration had already begun in quite a percentage of cases.

The mesenteric glands were congested, the brain was anæmic, and the ventricles filled with serum ; some hypostatic congestion was observed in both lungs.

The stomach, ilium and colon were the portions of the mucous tract to suffer most, and the duodenum and jejunum were the parts least affected.

Some portions of the intestine contained a grayish green substance like that seen in the discharges. The transverse colon, cæcum and sigmoid flexure were distended with gas and contained the same green substance as mentioned above.

In taking up the treatment of cholera infantum, I will make some divisions which will simplify matters : first, hygiene ; second, remedies ; third, supply fluid to the system ; fourth, reduce the temperature ; fifth, how and what to feed.

In all cases, at the outset I insist on twenty-four hours' rest for the stomach ; in this way the violent poison supposed to develop from milk in the stomach is given a chance to be eliminated from the system.

Also all the vomiting and purging that nature is putting the patient through is to bring about this same idea of the elimination of the poisons from the system, and nature is a most wonderful agent in this regard if only she has a chance.

First. Under hygiene may be included a change of climate or change of location, from the city to the country and from the city to

the seashore ; I have seen most astonishing results follow both these changes. The change should be long enough to decide of how much benefit it is to be to the patient ; and if a favorable change comes, it should be long enough for a complete cure to take place. Fresh air in shady places should be sought, and the little patient should live out doors as much of the time as possible ; the child may ride in a carriage, or be rolled along leisurely in its easy chair, or swing in a hammock.

Flannel should be worn next to the skin, and especially a warm woolen flannel should encircle the bowels, and afford that uniform warmth to the bowels that is of so much moment in the successful treatment of all these cases.

Warm blankets should be the child's protection at night. We must bear in mind that the bowels are the vulnerable point, and must be kept warm and well protected from all climatic changes, or we shall see serious results follow.

All through the disease I insist on sterile napkins being used, and a complete change of clothing every day throughout ; absolute cleanliness must be observed if we expect to cure our cases.

In case of cold extremities always wrap the feet in warm flannels and put hot water bottles to the feet to keep up the heat, being careful to so wrap the bottles that the child will not be burned by their use.

One other suggestion may be made right here, and that is not to feed a child or allow it to drink from a dipper or tumbler until you know it to be absolutely clean or sterile.

By observing these few suggestions we can at least lay the foundation for a most satisfactory treatment to follow, and have the pleasure of seeing our little ones many times restored to health and happiness, when a little neglect would have resulted otherwise.

Second. Now a word in regard to remedies and their sphere. You and I both have awaited their action in breathless silence, and seen the little one grow weaker and weaker until its pulse could no longer be felt. We have spent long and anxious nights in search of the simillimum of a given case. The materia medica shows well-worn leaves as strong evidence that the remedy has been most patiently sought after, and still no specific has been discovered.

The remedies I most often use are arsenite of copper, arsenicum, aloes, croton tig, chamomilla, camphor, ipecac, merc. cor., and podophyllum. It has been my good fortune to find the case more nearly covered by the arsenite of copper than any other one remedy. The ars. seems to cover the nausea, the emaciation, the loss of strength, the cadaverous look, and the cuprum meets the crampy pains, the tendency to convulsions, the violent cramps in the abdomen, convulsive vomiting, the peculiar green stools with flocculent matter so often met with ; so I think this combination the best, and it has cured more cases than any other one remedy in my hands.

Third. Under the head of supplying fluid to the system, all of us have witnessed the ready response the pulse makes following an operation attended by shock, when the saline sol. is used. It seems to me in true cholera infantum we have almost a parallel case, where the fluids of the body are just as much depleted as in a case of shock following an operation.

So I have come to use a saline sol. in most of these cases, giving an injection high up in the bowel through a No. 15 male catheter of one half pint at a time; and if this does not raise the pulse to its normal strength I use one-fourth pint injected into the cellular tissue of the abdomen, buttocks, thigh or back; this can be done once in eight or ten hours and is readily absorbed, and has never done any harm.

Two years ago this summer, while in New York doing post-graduate work, I had my attention called to Wolf's electrozone, and saw it used in all forms of orificial surgery with the most gratifying results; and I was led to try it in cholera infantum as an injection, both for its fluid supply and its antiseptic properties. I use it the same as the saline sol. and about four ounces at a time, and repeat every four hours if well retained. I employ it full strength, and have seen such beneficial results that I should be loth to deprive the little sufferer from its most pleasing effects.

I have also employed merc. cor. 1 to 5,000 to irrigate the bowel with, also carbolic acid 30 m. to the pint, and a few times 1 x argen-tum nit. in a weak sol. But for two years I have used either the saline sol. or electrozone, and have found them so well filling the need that I have used nothing else during that period.

Fourth. Next we come to the matter of reducing temperature; and I have yet to see the first case of true cholera infantum that did not carry quite a high temperature. The best method of reducing temperature is by baths, given just as a bath is given in typhoid fever, commencing the bath at a temperature of 100°, and continuing to cool the water until it reaches 80° or 85° by adding ice to it until it reaches the desired temperature.

These baths should be continued for from ten to thirty minutes, and be repeated as often as the temperature reaches 102°. They should be made available by using a small tub into which the child can be put, or by the ordinary sponge bath—always bearing in mind to cool the water by adding pieces of ice until it reaches the desired temperature. In either case the result is accomplished and the fever greatly abated.

Fifth. Our next section has to do with the nutrition of the child and its method of taking it.

Following the experience of earlier years, some of which was not so pleasant as it might be, I always since have made it a rigid rule to employ a wet nurse for all children under six months old where one

can possibly be obtained. I consider this the most important step toward the little one's recovery.

As a rule, with older children I discard cow's milk or condensed milk, whichever the child may be taking, and put the child upon a diet of some of the well-established and favorably recognized foods on the market; namely, Mellin's, Nestle's, or Lactated, with the juice of raw meat added in the proportion of one half teaspoonful to each feeding, or five to ten drops of bovine to each feeding. I also use with these foods rice water, barley water, and oatmeal water, using these to vary the diet and increase the nourishment of the child. I add one tablespoonful of these foods to each feeding, and insist that the child should not be fed oftener than once in three or four hours, and with great regularity.

To increase the nutrition, I also use inunctions of cocoa butter, olive oil, cream, or cod liver oil, or lard with the addition of bovine or beef juice, one teaspoonful to each inunction. In long-continued cases I have found this to be one of the best means of sustaining the child's strength.

Cold koumiss I have used in a few cases, and have found it to work well and sustain the strength; and it is well borne by the sensitive stomach.

To supply albumin, of which there is so great a loss to the system, we find that the white of an egg beaten into cracked ice or very cold water and fed in teaspoonful doses, as the child needs it to assuage thirst, is the best means of supplying the system with this much-needed food. Wine whey, malted foods, animal broths, liquid peptonoids, all find a place in the diet list until we are satisfied that the child is being well fed and well nourished.

For stimulants I use both whiskey and brandy, and in about the proportion of one to six, and give one dram of that mixture every hour if needed. I have also used champagne, and seen good results from its use.

In desperate cases I also resort to rectal alimentation of milk and brandy, with pancreatin added, once in four hours until the stomach will do its work again, and the child is going on to a rapid recovery. Sometimes I add the indicated remedy to this injection if the stomach is intolerant, and find it is well adapted to this class of children.

In closing I will mention three cases treated during the months of July and August of the past year.

Case No. 1. Baby A., five months old, had a cholera infantum grafted on to an acute bronchitis; temperature 103°, pulse so rapid we could count it with difficulty; vomited and purged incessantly; tongue dry and parched; bowels full and tender to the touch; extremities cold and clammy. This was a condensed milk baby, and the mother would give it nothing else. I gave in addition beef juice and white of an egg, and stimulated with brandy, used ars. and verat.

alb., applied hot water bags to the feet and legs, wrapped the bowels in warm flannel, and gave the cold sponge baths to control the temperature.

Dr. Burpee saw this case with me, and recommended saline sol. injections, as I had done before, but which were never carried out. We both tried to get the baby for the seashore hospital, but in vain. The child grew weaker and thinner, and in a few days was laid to rest.

Case No. 2. Baby B., aged four months, was taken on July 10 with violent vomiting and purging, which kept up on an average of once an hour for the first twenty-four hours ; temperature 104° , pulse 160, restless and moaning, tongue dry and parched. This baby was bottle fed, and had cow's milk. I secured a wet nurse and put the child upon arsen. of copper with electrozone injections well up in the bowels through a No. 15 male catheter, repeated every four hours for the first twenty-four hours, then once or twice a day for the next week. Cold sponge baths every four hours were given. Temperature was reduced in forty-eight hours and the pain subsided, and the child went on to an uninterrupted recovery.

Case No. 3. Baby C., aged one year and two months, was taken August 10, 1898, with most terrible vomiting, and attended by watery discharges from the bowels. Bowels were bloated and tender to touch, child moaned and had that pitiable look we all dislike so much to see. I made careful inquiry, and found that, one week before they had called in a doctor, and he had given castor oil for three or four days in succession, and the child had got no better, so they decided to see what a change would do for the little one.

I found a temperature of 103° and a pulse of 170, continual swallowing and retching when not vomiting ; every particle of food taken was thrown violently up as soon as taken. I began the treatment with ars., and ended the case with the same remedy, changed to Mellin's food and bovine, five drops to each feeding, used the baths to reduce the temperature, and gave saline sol. injections every four hours for the first twenty-four hours, and then continued them once or twice a day for the first ten days. Covered the bowels with warm flannels, also the feet and legs ; sterile napkins and absolutely clean clothing were substituted for those worn, and we were soon rewarded by seeing the little one begin to make some improvement. In this case there was a great loss of flesh, and I employed the inunctions of olive oil night and morning, with the most satisfactory results, for several weeks.

DISCUSSION.

Dr. C. C. Burpee thought the paper so complete and had so thoroughly covered the ground that there was little left for discussion, and there only remained the relating of the individual experience of each one in this disease. He would dismiss the pathology with only this word of warning, that unless the autopsy was held within a few hours of the time of death, you could not rely on the changes in the alimentary canal, as the condition found after a short interval resembled, and was practically, the same as that which took place naturally after death. An autopsy must therefore be held at once or we could not speak positively of the condition as proving the presence of cholera infantum.

As to the treatment he wished to say a word in condemnation of condensed milk, and to warn against its use, as his experience of the past summer had demonstrated its many dangers to him. He had a chart which he wished the members to examine, taken from Holt's work on Pediatrics, and wanted them to notice especially the small amount of fat and the excess of sugar as compared with mother's and cow's milk. Another bad feature was that sugar found was cane sugar and not sugar of milk, and the former undergoes much more rapid fermentation in the baby's stomach. Another thing which should be borne in mind was the small size of the baby's stomach, a fact seldom considered by parents. It might be of interest to the members to note that the four babies who died, and the sickest children at the Sea-Side Hospital, last summer, each and every one of them had been fed on condensed milk. Such children are predisposed to cholera infantum, and when this disease attacks them, they will wilt like the flowers. Condensed milk gives no stability or firmness to the muscles and bones, and he had never yet seen a case of rickets which had not at some time or other of the child's existence been fed upon this worst kind of food.

The importance of using sterile water, and having drinking cup, nursing bottle, et cetera, in the same condition, could not be overestimated. The giving of good, pure water to children, and not depending simply upon the milk as a drink, would be of great assistance to every child. The medicinal treatment had been so well set forth in the paper that there was nothing more for him to add in that direction, but he wanted to emphasize the great amount of relief which was often obtained by the use of the high injection. It was not necessary to have a normal saline solution, for it was the custom at the hospital, last summer, to use the sea water without any change, except to sterilize it. When the baby is restless and crying out with tenesmus, and upon examining the abdomen, you find the intestines in a knotted condition, a high injection will give great relief, and many times, a child, which had been crying and sleepless for hours, will immediately drop off to sleep, so prompt is the relief.

Upon the temperature of the child must depend your use of either hot or cold water. If the temperature is high, and you start with the injection fluid at 100° F., simply add a small piece of ice, and your fluid will be gradually lowered in temperature, and the result obtained will be most satisfactory. Repeat the operation every time the temperature gets above 102° F.

In closing he wanted to reassert his warning never to give condensed milk to any of these little patients.

The President presented a brief verbal report of a case of *Elephantiasis of the Hand*, with X-ray pictures, before and after the operation of removal of the finger, which measured $9\frac{1}{4}$ by 10 inches.

REPORT OF THE COMMITTEE ON OBSTETRICS.

JOHN F. WORCESTER, M. D., *Chairman.*

- I. A Peculiar Case of Ectopic Gestation, Chas. W. Morse, M. D.
Discussion opened by W. H. Stone, M. D.
- II. Occipito-Posterior Positions, John F. Worcester, M. D.
Discussion opened by Sarah S. Windsor, M. D.
- III. A Paper, Geo. R. Southwick, M. D.

A PECULIAR CASE OF ECTOPIC GESTATION.

BY CHAS. W. MORSE, M. D., SALEM, MASS.

The object of this paper is to bring up this case for discussion, not that there is any special claim for the treatment, but because we believe many cases diagnosed as early abortion, are, in reality, extra-uterine pregnancy.

October 20th I was called to see a woman suffering intense colicky pains in the region of the left ovary. She was thirty years of age, tall, nervous, anæmic, had menstruated a week and been well one day. The menstruation was apparently normal, that is to say, she usually had some pain the first day and the flow was quite profuse. She was the mother of a six-year-old girl, had miscarried two years previously at four months. A year later was curetted and has enjoyed fair health ever since.

The patient was suffering apparently from an attack of tonsillitis, pulse 120 rapid and full, temperature 102°, skin dry, hot, pupils dilated, nervous, excited, face alternately flushing and blanching, twitching of the muscles of face and extremities, throat sore and painful on swallowing, tonsils enlarged, severe colicky pains in the abdomen, especially the left ovarian region. She had recently contracted a cold and had been eating sausages that evening. Gave Bell. and ordered an enema.

Next morning called and found very little improvement though a good movement of the bowels had been secured. Continued the Bell. enema, and ordered turpentine stupes to be applied to the abdomen.

In the afternoon the flow began and increased rapidly in quantity, being dark in color, almost black, with shreds of mucus and disorganized tissue, twenty-five napkins being used in twenty-four hours. This flow gave some relief and in a few days she was up and around and for a week or more seemed to be convalescing.

Still at times she would have severe pains about the left ovary, but not of long duration. Bowels moved regularly and she kept at work about the house.

Nov. 9th she was seized with a sudden paroxysm of pain in the left ovarian region, throbbing, bursting, bearing-down pains, simulating labor-pains, moving down and centering in the groin; when pains ceased in the ovarian region they went to the back with four fold intensity. During the week previous she had been flowing afternoons so as to soil three or four napkins but not at any other time. I made an examination, giving etherated air, and found a distinct tumor to the left and a little posterior to the uterus, the uterus being pushed a little to the right; distinct pulsations of the blood-vessels of the tumor could be felt. Tumor hard and tense, about the size of a pullet's egg.

Pulse 130, temp. $104\frac{1}{2}^{\circ}$. Had cold chills that morning and was nervous and excited. Sent for Faradic current and used it immediately, one pole in the uterus and the other on the abdomen in the region of the tumor. Gave Apis.

That night she rested comfortably and enjoyed relief from pain such as she had not experienced before. Temperature dropped to 100° , pulse to 86. Diagnosis was ectopic gestation.

The high temperature and throbbing pains would indicate pus in the tubes, salpingitis; if an early uterine abortion there would not be so much suffering.

Nov. 10th consultation was held, it having been urged the previous day as soon as the case was diagnosed. The consulting surgeon advised removal to the hospital for safety and further observation, which was done Nov. 12th temperature having become normal. Flow stopped the 14th, but a yellowish discharge followed sufficient to stain napkins, bowels became constipated, necessitating daily enema.

Improved continually until Nov. 20th, no medicine having been given. That night at 12 P. M. was taken sick as before with severe pains in ovarian region. Temperature rose to 101° . Plans were made to operate next day after consultation of five physicians.

During consultation a movement of the bowels eased her so much they decided the pains were menstrual in character and decided to postpone the operation. Temperature returned to normal, and she left the hospital the 26th having been there two weeks.

The menses stopped a few days after returning home, having lasted a week and thirty napkins used.

About Dec. 5th the pelvis was X-rayed, three pictures were taken and in each a light circle appeared in the region of the left ovary as above described. The patient continued to improve with only occasional dull pains, until the next menstruation when she remained in bed five days. It appeared normal and since that time she has been enjoying her usual health.

A second X-ray photograph was taken April 9th when nothing unusual was observed. The object of these photos was diagnostic as well as therapeutic.

In examining the records of a number of cases of ectopic gestation we find there is no symptom or group of symptoms, on which we can absolutely rely in differential diagnosis between this and early abortion. The usual symptoms given by writers on this subject as pathognomonic of this state are first, irregular hemorrhage, followed by longer or shorter delay of menstrual period; second, discharge from the uterus of decidual membrane; third, colicky pains.

The irregular hemorrhages resembling those encountered in ectopic gestation may occur in uterine pregnancy. There is nothing in the appearance of the blood indicative of one condition or the other unless in uterine abortion the flow is apt to be more profuse.

It is true an irregular flow or spotting encountered in a woman who has always been regular, but who has now gone one, two, or three days over time should make us suspicious of ectopic gestation. The symptoms should put us on the alert but we ought not to attach too much importance to it singly.

The question as to whether uterine hemorrhages, consequent upon a ruptured tubal pregnancy or tubal abortion may occur before the onset of the next menstrual period, in other words, without amenorrhoea, must be answered in the affirmative. A number of such cases have been placed on record by reliable observers. In these cases rupture of the tube takes place before the time elapses for the next menstruation. A great stress has been laid by many writers upon the discharge of decidual membrane or tissues from the uterus.

There can be nothing more misleading than this symptom.

Firstly.—There is no membrane discharged in a number of cases, the decidua being cast off in shreds or undergoing degeneration. Secondly.—It may be expelled in clots. Thirdly.—The patients will often say when questioned that she has passed a semi organized blood clot.

Lastly and most important fact, the most expert microscopist cannot distinguish between decidual tissue from uterine and tubal pregnancies. This last nullifies the advice given by some authors to curette the uterus in suspicious cases, and examine tissues removed for decidual cells.

Colicky pains are characteristic. At one time they may be sharp and lancing, and again resembling bearing-down pains of dysmenorrhoea. They may simulate ordinary colic or labor pains or throb like an inflamed ovary.

Fainting spells are the strongest and most suspicious symptoms, especially in very anæmic subjects. Classical cases with slight enlargement of the uterus, and readily distinguishable elliptical tumors behind or to one side of the uterus are very important and must be differentiated from ovarian tumors, salpingitis, retroflexed pregnant uterus, appendicitis, etc.

OCCIPITO POSTERIOR PRESENTATIONS.

BY JOHN F. WORCESTER, M. D., CLINTON, MASS.

In presenting the above subject for your consideration, I do not expect to revolutionize your ideas concerning occipital post. presentations of the foetal head, but possibly present many of your unformulated opinions and actions which speak louder than words.

We have all studied text-books on Obstetrics, and we have all wondered why O. P. pres. were so shortly dealt with, in most text-books the percentage of O. P. are given, then it tells how to determine when we have an O. P., tells us also that when flexion of head on breast is not maintained that we shall have the long diameters of the head, oc. frontal or even occipito-mental, stretching the muscular outlet of pelvis, within bony pelvis great compression of head, and tearing of soft parts of mother and perhaps death of child and of mother, and if conformation of head or pelvis is too close, delivery by forceps and perhaps a live child, perhaps not, injuries to the mother, perhaps fatalities and so on. Or, if flexion is well maintained, the occiput will descend on to perineum and resistance be lessened, the occiput will swing round below ischial spines, the pubes acting as fulcrum on which the circle of the head turns, for the head is not a simple lever but a spherical body, one contending with varying planes of resistance and transmission of forces. Finally the occiput will come under the pubes and the head will be born as in anterior positions of the occiput.

Now all this sounds very easy, and so it is if things are just right, but it seems to me that we are dealing with something too precious in human life and human health to submit longer to a mode of practice that is trusting so much to chance. In most malpresentations of the foetus at the pelvic brim we are instructed, and rightly, to interfere before the parts are fixed in the bony pelvis, and before the amniotic waters have escaped, making it both *comparatively safe* and *easy* to change the position of the child to a more favorable one and have far better outlook for both mother and child.

In occipito post. presentation we have important conditions to deal with, and they should be met before the time is past when it can be done with safety.

We find this presentation according to Winckle of Munich, in 1732 births, 93% are occipital presentation, of these 1.26% are occipital post. Playfair claims that 4% of occipital post. presentations do not rotate into either 1st or 2d occipital presentations.

In the American text-books of Obstetrics, the only one advising interference before labor has far advanced in O. P. P., gives statistics from a large number of labors with varying percentages of occipital

presentations. 97% down to 83%. 75% occipital left of these 2% are occipital left post., but 25% occipital to right side of mother, of these it says, in the early stages of labor before head is pressed into brim, a large part are occipital r. ant., but as soon as engaged in brim become occipital r. post., and in the latter part of second stage again rotate and become occipital r. ant.

The causes of O. P. presentations are not clearly defined. Winckle says that the failure to rotate is usually due to some pathological condition, pelvic deformity, or general narrowing of pelvis, prolapse of cord or of arms, more than anything else perhaps a large head. This last in this country will perhaps explain more than any other cause the reason for our difficulties in this position of the child. I have found it so in my own practice, that with small heads in a normal pelvis, that rotation and natural delivery take place, but in a large percentage of cases a large foetal head prevents the flexion and descent of head and we are forced to interfere to save mother even if child has to be sacrificed. Determination of position of child is made by external palpation, the head is found on deep pressure over pubes, in thin subjects the contour of face may even be felt, especially so in occipital post. presentation. The back lies further to the back of mother, the heart sounds are heard much further to the back of mother than oc. ant. pres. and the small parts lie on the front and opposite side to the back.

By vaginal examination the head is felt as in all occipital presentations, but in O. P. P. in the early stages of labor the sagittal suture is in a post. oblique diameter, the small fontanelle at post. portion of this diameter, the large one at anterior end, the lambdoid suture, coronal suture, ears and forehead, eyes and nose, if the examining finger be introduced high enough.

In the later stages after the cervix has dilated it is easier to determine the position as the guiding points are more readily reached, and position of sutures and fontanelles depend upon stage of labor and the course it has taken.

It has been my own experience, and I find the same point spoken of in the American Text-Book of Obstetrics, that in most cases labor of perhaps normal pelvis where the head fails to come readily into brim of pelvis that the condition is one of occipital post. presentation.

This is due to two causes, first, that the biparietal diameter of head comes in the short diameter from sacral promontory to ilio pectineal prominence, and if head is large it does not readily engage, or if pelvis is contracted or deformed and head normal the result is the same; and also probably from the lack of proper engagement and consequent impaired flexion or even extension of head descent does not take place and we get irregular and insufficient uterine contraction.

The important fact to be borne in mind in these cases is, that if labor is to be terminated normally, that is, rotation is to take place, that the head must enter brim and also enter cavity of pelvis in a well-flexed position, pressure on frontal portion of head by examining finger is often and perhaps usually enough to accomplish this, and the occiput descending more rapidly comes to floor of pelvis, the occiput lies in the hollow between sacrum and ischium on either side depending on the diameter occupied, the frontal portion at the forward or pubic end of oblique diameter, descent taking place the occiput is forced downward and forward along the post groove and the occiput rotates backward on the ant. lateral wall of pelvis, and the occiput continuing to rotate along anterior groove the occiput comes under pubes and delivery takes place as in first and second positions of head.

If flexion does not take place the forehead descends and we have a frontal presentation or even extreme extension and a face presentation with greatly increased danger to mother and child, or there may be moderate flexion and the forehead lodge behind pubes and the occiput and forehead distend vaginal outlet and we get extreme distention of perineum or rupture of same, or the descent stops here or even higher up in cavity of pelvis and instrumental delivery is needed.

There are a number of ways advised in the handling of these cases of occipital post. presentation.

First, those cases where before labor has begun we find this position present, the patient should be directed to take frequently the knee and chest position, to keep off her feet as much as possible, to lie on the opposite side to that which the back of the child may lie hoping gravity will tend to rotate child into an anterior position.

Second, To promote flexion at brim and in cavity of pelvis and try and promote rotation in this manner and normal ant. delivery.

Third, When head has entered cavity of pelvis and rotation does not occur to apply forceps, reversed forceps, and try to rotate head in pelvis, a dangerous and difficult proceeding, or to apply forceps to sides of head and do the same, or deliver rapidly in the post. position; this last where progress is stopped and condition of mother and child indicate interference.

Fourth, To raise head from pelvis, when it is freely movable and if possible, before amniotic water has escaped, with cervix well dilated, and rotate into an occipital anterior position, hold it there, and if necessary rupture bag of waters and trust the contraction of uterus will prevent return to former position. In such cases where the head does not engage and such manual rotation does not succeed, version should be made, but this is not often necessary; and occasionally I have found that by applying high forceps after manual rotation the results were most satisfactory.

To sum up in a few words—

It seems to me that interference in all doubtful cases of this presentation, is indicated and should be made before head has become fixed in pelvis, before waters have escaped, making rotation at brim both safe and easy, and if necessary, high forceps applied and rapid termination of labor, or podalic version made and rapid delivery in this manner effected.

I cannot understand why we should adopt an expectant attitude in these cases any more than in face or brow presentations, or any other malposition of the child, when we have a large head and a small pelvis or any disproportion of head and pelvis likely to prolong labor and endanger mother or child, when by proper care at brim while child is freely movable we can do almost anything in the way of interference with very little danger to either mother or child.

PRACTICAL POINTS IN THE PRACTISE OF MIDWIFERY.

BY GEORGE R. SOUTHWICK, M. D., BOSTON, MASS.

“There is nothing new under the sun” and the writer asks your kind indulgence if the few suggestions prove to be old saws, as he thinks they still cut ice. Version under some circumstances is not only a difficult operation but may be attended by great danger of rupture of the uterus. This is especially true of neglected cases when the presenting part is wedged tightly in the brim, the cervical zone thinned out and the contraction ring high in the hypogastrium. The Trendelenburg position is of great value in such cases combined with suspension of the legs. Dangerous cases may be converted by this procedure into comparatively easy ones for performing version.

A difficult breech extraction has made many an anxious operator perspire. It is a question as to which man is the most valuable, the operator extracting the child or a trained assistant who knows how and when to make vigorous supra-pubic pressure on the head as it passes through the brim of the pelvis. It is the rule of some of the most expert operators it has been my good fortune to know, to send at once in every case of breech presentation for the best assistant obtainable. If such a case is complicated further by a minor contraction of the pelvis, Walcher's method of suspension of the legs will add about half an inch to the conjugate diameter of the pelvic brim.

The secret of success in applying forceps is to use them at the right time; apply the blades over the sides of the head and in delivery to imitate the mechanism of labor in rotation as well as in flexion and extension of the head. The natural tendency is to operate too early rather than too late.

A laceration of the perineum often means a laceration of the vagina; early suturing is desirable, but may be deferred several hours if the patient is much exhausted or if better light can be obtained to place the vaginal sutures accurately, which is very important to obtain the best results. Poor union may be due to too many sutures which strangulate the vessels carrying nutrition to the wound or to tight sutures which cut out. Good light and a free exposure of the wound are necessary to ascertain the entire circumference of the laceration.

Sharp pains in the hypogastric region in early pregnancy are to be regarded as suspicious of ruptured tubal pregnancy and the latter may closely simulate an acute appendicitis.

Eclampsia is almost sure to be preceded by a full, almost wiry pulse. It has more significance even than the albuminuric retinitis which may be detected by the oculist before the family physician or his patient suspect the approach of such a serious complication.

The writer has found *Veratrum Viride* in physiological doses a most valuable remedy for such a pulse.

Valvular diseases of the heart are especially prone to develop into ulcerative endocarditis after labor if special care be not taken to conduct labor and the puerperium under the most strict observation of asepsis. The septic germs lodge readily on the roughened valves and thus infect the heart.

If the uterus at full term is very erect, there is good reason for suspecting either a contraction of the brim, or disproportion between the child in the position it occupies and the pelvis. If there is room for the closed fist of the average size of a man's hand to rotate around in the brim there is also room to deliver an average sized child through it.

There are few things which cause more anxiety than a high temperature in the puerperal period, but not every high temperature is of septic origin. The habit of taking the temperature and pulse both night and morning in every case, no matter how normal, for the first ten days of the puerperium is invaluable for diagnosis and prognosis if the temperature goes up. If the rise of temperature first occurs after the ninth day, puerperal sepsis is excluded, except the remote possibility of a septic clot retained in utero. A falling evening temperature, i. e., a temperature lower on successive evenings is of very favorable import though the actual temperature is high. A steadily rising pulse in septic infection points in an unfavorable direction. Hysteria or some excited condition of the nervous system, is liable to cause a sudden and high rise of both temperature and pulse, but both recede promptly within twelve hours and remain down.

Malaria may simulate sepsis closely, and the temperature either show fairly regular intermissions at first or there may be a comparatively continuous high temperature for a few days and then the intermissions occur. The examination of the blood with modern methods of staining shows the presence of the malarial plasmodium and the effect of quinine is a further proof of the cause of the temperature.

There is no one thing which will make the practitioner rest more easy about his puerperal patients than strict asepsis during and immediately after labor.

The same care given then which the surgeon gives to his cases of laparotomy will be equally well rewarded. Merely dipping the examining fingers in an antiseptic solution or even thorough washing of the hands do not constitute a safe antiseptic treatment of the case.

The treatment of incomplete abortion is an unpleasant chapter in the professional work of many physicians. The early and complete emptying of the uterine cavity, especially in criminal cases, will save many an uneasy quarter of an hour. The finger is the best instrument but often must be supplemented by the curette. Thorough douching afterwards, followed by the peroxide of hydrogen and a generous wick of iodoform gauze is a very effectual plan of treatment.

There was no discussion on the papers of this committee.

Dr. Frank C. Richardson said he wished to express his appreciation of the favors and kindness shown him by the members of the Society, during his ten years of service as Secretary. The President in reply said that he was sure the Society would agree with him in saying that the Society was rather the debtor to Dr. Richardson for his faithful performance of arduous duties.

On motion the Society adjourned.

PROCEEDINGS OF A SPECIAL MEETING.

JULY 5, 1899.

This meeting was called by the President, Frank C. Richardson, M. D., to take action upon the death of our late colleague and leader Dr. I. Tisdale Talbot, and was held in conjunction with the Massachusetts Surgical and Gynæcological, and the Boston Homœopathic Medical Societies. Frank C. Richardson, M. D., in the chair. Remarks of respect and affection were made by Dr. Conrad Wesselhœft, Dr. Benjamin West, Dr. Horace M. Paine, Dr. F. H. Krebs, Dr. J. H. Sherman, Dr. Alonzo Boothby, Dr. H. C. Clapp, Dr. A. B. Church, Dr. H. E. Spalding, Dr. H. L. Chase, Dr. Martha E. Mann, Dr. S. S. Windsor, Dr. J. E. Briggs, Dr. A. L. Kennedy, Dr. Horace Packard, Dr. J. P. Sutherland and Dr. J. F. Worcester.

It was voted that a Memorial Meeting be held in Boston, at some future time, when members would be at home and adequate thought could be expressed, under the auspices of the Massachusetts Homœopathic Medical Society. It was voted that the Executive Committee of each body of which he was an active member should constitute a Committee to arrange for this Memorial Meeting.

It was also voted that a notice of the death of Dr. Talbot be sent to every alumnus of the Boston University School of Medicine.

Adjourned at 1.15 P. M.

PROCEEDINGS
OF THE
FIFTY-NINTH SEMI-ANNUAL MEETING.
OCTOBER 10-11, 1899.

The fifty-ninth semi-annual meeting of the society was held at the College Building, Tuesday evening, October 10, and at Steinert Hall, Wednesday, October 11, 1899.

EVENING SESSION.

The meeting was called to order at 7.30 P. M. by the President, Frank C. Richardson, M. D.

Charles H. Mohr, M. D., Professor of Materia Medica in the Hahnemann College of Philadelphia, was introduced by the President and invited to participate in any of the discussions of the meeting.

REPORT OF THE COMMITTEE ON MATERIA MEDICA.

WALTER WESSELHOEFT, M. D., *Chairman.*

- I. Some Clinical Experiences with Iodine, and Reflections Thereon, F. B. Percy, M. D.
 - II. Similia on Headaches, N. M. Wood, M. D.
Discussion opened by E. E. Allen, M. D.
 - III. Suggestions regarding the Re-proving of Drugs, Walter Wesselhoeft, M. D.
-

**SOME CLINICAL EXPERIENCES WITH IODINE, AND
REFLECTIONS THEREON.**

BY F. B. PERCY, M. D., BROOKLINE, MASS.

To the earnest student of Materia Medica who wishes to substantiate our claims as specialists in therapeutics, two courses are open; one the work of construction, the other that of corroboration. To the former belongs the proving of new remedies and the re-proving of others; to the latter, verification of pathogenetic effects or perchance nullification of inferences previously drawn. Some two years since,

I read and cut out for future reference, a most fulsome laudation of a remedy hitherto unknown to me. Whatever literature was available I gathered together and great was my delight when this last year it was chosen as a remedy for a careful proving. An enthusiastic and willing body of workers offered themselves to this task and their symptom lists I had looked forward with pleasure to presenting for your consideration. Alas, our work was fruitless, and that too though a more recent article on this same drug, in a Western medical journal proclaimed this drug to be the most valuable contribution to medical science. In lieu of this I beg leave to offer this very humble contribution to a much disputed question the possibility of any remedial agent influencing the course of croupous pneumonia.

The reasons for my choosing Iodine in the treatment of this disease may be briefly summarized. First of all what Hughes in his Pharmacodynamics says of Kafka's use of Iodine "The term croupous pneumonia applied by the German pathologists to acute primary inflammation of the lungs implies for him the pathological identity of the two processes and he treats them accordingly. He maintains on the strength of a prolonged experience that if Iodine be administered when the physical signs first appear it will arrest the process of localization and in short the whole disease. He gives a drop of the 1st, 2nd, or 3rd decimal dilution every hour or even half hour and says that improvement may be looked for after the fifth or sixth dose and that within twenty-four hours the disease will be evidently conquered." A few years ago there appeared in the North American Journal of Homoeopathy, a study of sixty cases of pneumonia treated with Iodine in the ϕ , in which Kafka's statement was repeated. Soon after in the New England Medical Gazette, Dr. Calderwood wrote of his experience with Iodine in pneumonia. A new service in the hospital was about to begin and I determined that from Jan. 1 to April 1 every new case of pneumonia should be treated with Iodine, and orders to that effect were given to the medical internes. This was not a new experiment for during the past three years I had practised the method and with satisfactory results. Moreover Jorg's proving gives as clear a picture of croupous pneumonia in its early stage as one could ask for, and add to this the evidence offered by post-mortem examination demonstrating changes in the lungs unmistakably inflammatory, and we have symptomatic and pathogenetic reasons for the use of Iodine.

Six cases only of pneumonia were admitted to the hospital, and of these two can be dismissed very summarily. The first was Mrs. C. who was admitted for operation, but was found suffering with pneumonitis and transferred to medical side. Careful examination revealed carcinoma of right lung with acute symptoms and previous history was given of right breast removed one year previously. The cervical glands and left mamma were indurated and for their removal she had been sent to the hospital. It is needless to say that medicine was of no avail and

surgical interference not considered. The second case while diagnosed as pneumonia proved by a subsequent development to have been a case of pneumo typhus and the issue was at last unfavorable. The remainder of the group will be briefly considered.

Case 1. Mrs. T., age 25, admitted to hospital Jan. 2, mother died of consumption.

Father always well as also brothers and sisters.

Has had ordinary children's diseases, and four years ago had typhoid fever. Since then, as before, has always been well and strong.

Present illness began Dec. 27, with chills, severe cough, headache, dimness of sight, excessive weakness, severe pain in right lung.

On admission right lung was found consolidated throughout. Temperature 105.1° , pulse 120, respiration 40.

Iodine 1 x, drop doses hourly was prescribed.

Jan. 3, patient more comfortable, expectoration almost clear blood, temperature, 105° .

Jan. 4, temperature 104.4° , pulse 120.

Jan. 5 crisis came after night of delirium.

Temp. 98.3° , pulse 90.

Convalescence was rapid and uneventful, and patient was discharged on Jan. 25.

Case 2, Miss K., was admitted Jan. 26 as convalescent for right sided pneumonia, and when first seen was found to have considerable dullness in lower lobe.

Iodine hastened resolution.

Case 3, Mr. B., student, age 18.

Was taken with severe chill Tuesday night, three days previous. This was followed by severe pain in left lung and severe cough with scanty expectoration. He was treated for some days by his family physician and Bryonia and Phosphorus had been given. Physical examination showed consolidation of lower left lobe. Expectoration bloody. Severe pains in left side. Temp. $103\frac{1}{2}^{\circ}$, pulse 114, resp. 38. Iodine was prescribed and on 4th day temp. was normal and convalescence uneventful.

Case 4. Miss S., age 26. Domestic.

Family history negative.

Previous health good.

Present illness began four days ago with severe chill, fever, pain in right lung and expectoration of rusty sputa.

On examination Feb. 1st, right lung was found inflamed with small area of consolidation in lower lobe.

Temp. 103, pulse 105., resp. 40. Iodine. ϕ

On Feb. 4, temp. and pulse normal.

Convalescence uneventful and patient discharged on Feb. 25.

What, if anything, do these four cases prove?

Surely nothing in confirmation of the abortive power of Iodine in the early stages, for through force of circumstances none were seen early enough for this purpose. Rather do they demonstrate the power of Iodine to control the pneumonic process in its later stage, and carry the cases through to a successful issue. Just how much influence it had or has in averting the serious complications so likely to supervene in this much dreaded disease, one cannot speak authoritatively. There was nothing miraculous in the recovery of any of the cases, the first alone presenting alarming cerebral symptoms on the third day of treatment. You all are doubtless familiar with the fact that the best authorities are agreed that "Pneumonia is a self limited disease and uninfluenced in any way by medicine. It can neither be aborted nor cut short by any known means at our command." With us lies the burden of controverting such opinions based upon seemingly indisputable facts. Of necessity there has not yet accumulated anything like the number of cases treated by Iodine that Fleischman has tabulated with Phosphorus, as the all important remedy. If the indication for Iodine seem to you as convincing as to me, and one cares to carry out Kafka's recommendations with reference to dose and its repetition we can soon accumulate statistics which will prove or disprove its claims.

Let us leave, if you will, this question sub judice but of another case which is submitted for your consideration there is no question of the curative value of Iodine. Saul R., age 18, was admitted to the hospital in Oct. His disease was diagnosed pleuro pneumonia, and on Dec. 28 physical examination showed absolute dullness of lower two-thirds of right lung posteriorly and an area somewhat less marked on anterior. Exploratory punctures brought no pus. Temperature was fluctuating daily from $100^{\circ}+$ to $103^{\circ}+$. Expectoration free, consisting of mucus, pus and blood. Dyspnoea from slightest exertion. Sleep restless, unrefreshing with inability to assume prone position in bed, many nights being obliged to sleep sitting up. Appetite good but emaciation was evident. Color anaemic, skin unhealthy and cervical glands enlarged somewhat. After frequent consultation with surgeons, operative interference was postponed. Examination of sputum revealed no tubercle bacilli and while this was not absolutely conclusive evidence against tuberculosis, the diagnosis was not positive. Iodine seemed the best indicated remedy and it was administered with no interruption, save two days, when an acute tonsillitis was troublesome. I need not weary you with the details of his progress, suffice to say that in February he left the hospital in perfect health and now, seven months afterwards, he continues well.

Said a professor of Materia Medica at the Paris Faculty: "It must be admitted that the scandal of our times is the shameful ignorance shown by an infinite number of physicians concerning the real action of drugs. Although our practitioners are pretty fair clinicians they

are almost all unaware of the true properties of the remedies which they handle every day with extraordinary heedlessness." The careful study of drug pathogenesis, the selection of the remedy for well marked indications, the use of the single drug must eventually make such criticism of Homeopathic physicians impossible.

DISCUSSION.

Drs. Clapp and Calderwood, who were to discuss Dr. Percy's paper, were unable to be present.

Dr. Hiram L. Chase when called upon by the Chairman, Dr. Wesselhoft for something from his experience said, "I am very glad indeed to say something, but I have had no time to think about this subject, and it is a subject which requires a great deal of thinking. I have used Iodine a good deal, and in many cases with very excellent results. I have usually given it where there has been a great deal of depression of the system."

A SIMILIMUM FOR NERVOUS HEADACHES.

BY NELSON M. WOOD, M. D., CHARLESTOWN, MASS.

In the proper selection of the similimum for the varying symptoms met in common diseases, lies a very important part of the physician's work. Each new case may present new symptoms or pathological conditions quite different from others that seem upon the first glance to be just the same, or nearly so.

To be a successful prescriber, and I mean by that, one who relieves or cures his patients quickly and easily, he must carefully study each case from its pathological standpoint, and then make his selection from a *few* remedies having a close pathogenetic condition in general, rather than a great *many* of an entirely different general picture but having a few symptoms like the case to be dealt with.

Many of our oldest and most common remedies continue to be our most valuable aids. The better we understand them, the more we value them and look to them to relieve our cases. A few new ones, however, that have not yet been extensively proved, are doing great service in places that the old ones have not entirely filled. Such new ones as are of real service we cordially welcome but do not wish to accept too many, if by doing so we forget or neglect the old ones.

Perhaps no more common trouble exists or is presented to the general practitioner for relief by selection of the proper remedy, than that included under the broad term "*Headache*." I shall not endeavor to treat this subject very extensively, but shall mention only a class of cases that have particularly interested me, because of the relief afforded them by a favorite remedy.

I do not expect to edify older and more experienced practitioners than myself, but do hope that some younger ones may be helped by some suggestions given as experience upon this subject.

The neurasthenic headaches that constitute such a large percent of the cases in American women, especially those who are subject to constant nervous exhaustion from grief and anxiety, as well as to those given to society excitements and pleasures, are frequently met and often hard to relieve. They occur frequently in women not particularly active in society or under any great mental strain, but from simply going shopping, receiving callers, hearing unpleasant news, etc.

No special pathological lesion can be found in most of these cases, but there is always some nervous depletion and as is frequently expressed, a "general run down condition."

These headaches are usually diffuse with a general tired, confused feeling, more or less sensation of constriction or squeezing, and if the patient is hysterical, sharp boring pains are felt. These symptoms vary greatly according to the different constitutions and environments of different patients.

The main part so far as symptoms go, is to distinguish them from neuralgias and migraine, and it can usually be done.

For this class of headaches, the remedy that has proved most useful with me, is *Epiphegus Virginiana* or the Beech Drop. This is a low perennial parasitic herb, and grows upon the roots of beech trees. It is found all through the Eastern part of North America.

Very few provings of this remedy are to be found. One is in the *Cyclopedia of Drug Pathogeny*, and another in one of Dr. Hale's works.

After having used this remedy with the most gratifying success for over a year, I decided to make some provings myself on a small scale. The result is as follows :

I took teaspoonful doses of the tincture in $\frac{1}{3}$ of a glass of water, every two hours the first day, and after every dose had a distinct nauseated feeling which after a few minutes passed away and a sense of stimulation was felt. This in turn seemed to gradually grow into a general nervous, uneasy state, and I could not concentrate the mind easily on any single subject. About half an hour after beginning the proving a sharp boring pain was felt in the base of the nose, and back through the right side of the forehead. Later, pain was felt through the left temple and the whole head felt constricted. One thing noticeable about the pain, was that it felt as though it came from without, inward, and the sharp pain was not constant, although the constriction and confusion were present for several hours. After one dose of two drams of the tincture, a general headache, including marked pain in both ears and shooting upward in front of them, was felt within fifteen minutes there was particularly heavy pain back of the eyes. Nothing could be done to relieve the symptoms.

The provings I continued several days with smaller, but more frequent doses, and the results were practically the same. The pain was usually felt first through the right side, but sometimes came first, in the left side, and then was followed by a general headache.

I am positive that these headache symptoms with me, were not the product of imagination, as several times I went out on my regular calls, and every few minutes when I had entirely forgotten what I was doing with the drug I would experience sharp pains through my forehead which passed backward into the head.

Another proving, made upon a friend, a young women of nervous temperament, gave almost identical symptoms with the above, with the addition of a general numbness of the right side, but more pronounced in the arm. She also had very frequent, loose stools which lasted several hours. This person did not know, or even suspect that I was trying to get a proving of a drug, and voluntarily told me a few days afterwards how she felt after taking the tonic I left her.

Another healthy young woman, 22 years of age, took one dose of one dram of tincture well diluted, and in half an hour she had a severe headache, involving the whole head, but particularly hard in the forehead, and in left side. Pain was felt in, and in front of both ears, with a marked ringing in the ears, with dizziness. She was decidedly nervous and experienced considerable nausea. She felt like shutting her eyes, but when doing so, felt as if her head was full and in a whirl inside. This latter symptom I experienced several times.

The general picture given by these observations is practically the same as those recorded in the *Cyclopedia of Drug Pathogeny*, but lacks many of the less important symptoms, most of which were not experienced by any of my provings.

A typical clinical case, is as follows :

Mrs. L—, age 35, American, has had headache every two to four weeks for several years. She has grieved a great deal over the loss of her husband, who died six years ago. After any nervous strain or overwork, she has a general headache of the type previously described, beginning usually in the right side, at the back of the head, and then becoming general with a tired fulness and feeling, as if her head was in a tight case. These lasted from one to three days with the old remedies, including Bromo-Seltzer, Phenacetin and all the other remedies in common use. Since taking *Epiphegus*, which is about one year, she has had but one headache that could not be relieved by it, and that time it had been aching several hours before using it. Complete relief is usually obtained in from one to three hours in this case.

The method of administration of the remedy employed in most of my cases is to put from 20 to 30 drops of the tincture in a half glass of water and give two teaspoonfuls every 15 to 60 minutes, according to the severity of the case. In order to get the most pleasing results it should be used as soon as the headache is known to be coming on.

Many patients that are subject to very frequent headaches of functional character, are greatly benefitted by taking five drops of the tincture in water, three times a day. It lessens the frequency and severity of the attacks to a very marked degree.

In regular sick headaches that are not controlled by *Iris Versicolor*, *Sanguinaria* or *Melilotus*, *Epiphegus* may many times be used to alternate them with very beneficial results. This I believe to be particularly true with *Iris Versicolor*. Both need to be used *low* and *frequently*.

Another interesting case was Mrs. K——, 62 years, had suffered with nervous headaches, which usually lasted about 24 hours, as often as every three weeks, at least, for forty years. She did not believe in Homœopathic medicine at all, but one day while visiting another patient of mine, she was induced to take a few doses of *Epiphegus* and greatly to her surprise, in less than two hours she was entirely relieved. Many times since she has been relieved just as quickly, and now will not be without the remedy, and is a believer in Homœopathy.

One more case I wish to mention. Mrs. J.——, American, 27 years of age, fairly healthy, but of nervous temperament, had general diffuse nervous headaches about every week, or after any little excitement. *Epiphegus* always gave relief, and after taking it for a few months, it has apparently broken up the habit, and she has not had any headache for several months.

A great many cases could be given where it has proved equally efficacious, but these suffice to prove that it has some merit worthy of trial by those who have not used it, if there are any who have not.

It cannot be claimed that it is a specific for all such cases, as I have found some that it did not relieve to any great degree, but it has given relief in such a large percent of the cases, that to my mind, no other known remedy can compare with it in the good results obtained.

DISCUSSION.

BY EDWARD EVERETT ALLEN, M. D., CHARLESTOWN, MASS.

We have just listened to a paper the object of which is to bring before the profession a remedy which has been heretofore little known, and little used. The testimony which Dr. Wood brings forward is supported by quite an array of painstaking proving. This is the first time since my connection with Homœopathy in Massachusetts that I have known of any proving being done. It would seem that we as Homœopaths ought to be a little more active in this work of proving remedies, for do we not owe our existence and success today to the painstaking efforts of our predecessors along this very line? Ought we not to take up this work afresh, and with all the aid which might be derived from modern methods of diagnosis, the use of the microscope, the carrying it forward to more and greater triumphs in the future?

Dr. Wood called my attention to the use of *Epiphegus* in the treatment of certain nervous headaches about a year ago, and I purchased

some of the tincture of the drug at once, with a determination to use it at the first opportunity, upon one case in particular.

I had at that time a servant in my family who was troubled a great deal with severe periodical headaches. These always came on after a day of unusually hard work, especially if she did not retire early, or spent the evening out. She would wake in the morning feeling tired and nervous but usually without pain. This would come on in an hour or two and get gradually worse until she was forced to retire for the rest of the day and night.

Sometimes there would be nausea and less frequently vomiting, both coming on after the headache had been active for sometime. The face was at first pale, but as the pain increased it became quite flushed, especially so after lying down. It did not seem to me to be a true migraine; as the nausea and vomiting were not at all prominent features in the case. The stomach did not seem to have much if anything to do with it, as the pain always preceded the nausea, when it was present, and this latter seemed to be rather a result of the pain than its cause, moreover vomiting never relieved the pain but rather made it worse. There was no evidence so far as I could determine, pointing to liver or kidney disturbance. It seemed to me to be simply an explosion of pain due to excessive nerve tire, following considerable nervous and physical exertion. The pain was always most severe through the forehead and temples, described as a steady ache, with shootings of pain backward to the occiput, and from side to side.

I had tried many of our best remedies upon this case with but scant success, among them Iris, Gels, Bell, Bry and Sang, and upon hearing of *Epiphegus* I gave it to her at the first opportunity.

The first dose was given one morning for an attack which had commenced as usual and was getting worse. She ate no dinner and later went to bed for an hour or two, but appeared again about 3 o'clock much relieved and able to finish her work for the day. The next time that she complained of much nausea I alternated the remedy with *Iris* giving the *Epiphegus* with fifteen minute intervals, and the *Iris* half hourly, with the best of results.

I do not claim that she has been entirely cured of these headaches, but I can positively assert that she has passed over a period of four months without any sort of a headache, whereas before they were almost a weekly occurrence. I have found this remedy a valuable one in several other cases, but the one I have reported was the severest and most interesting.

I have made three provings of this remedy upon myself, with a view to ascertaining if it was a true *similimum* that we were using. I knew from past experience with drugs that a large dose would be necessary before I could hope for the best results, hence my first two attempts were not so satisfactory as the third.

The first time I took one half ounce of the tincture in teaspoonful doses, about half an hour apart. Each dose was diluted with about a tablespoonful of water.

Immediately after the drug was swallowed I felt slightly nauseated, and this was especially noticeable, when the drug was taken without much water. This passed off in a short time, without any desire to vomit. After I had taken the whole half ounce there came over me a decided sense of stimulation, which later became a true sense of nervousness, amounting to an inability to concentrate my mind upon anything without considerable effort, and with a desire to get out of doors. At this time I began to feel a slight pressing pain in the right parietal region, which lasted about an hour and disappeared. My proving had not given me a true headache, and I resolved to try again.

Two days later I took an ounce in divided doses as before, with no further result except that all of the above symptoms were intensified.

The third trial I took one and one-half ounces between 3 and 6.30 P. M. All of the symptoms experienced during my two previous attempts returned and about 5 o'clock a headache commenced in the right parietal region, pressive in character as if a hand was pressing downward in this region. The area of pain gradually extended, became much more severe in character, until the whole right side of my head was involved, the pain being worst just above the right eye, and extending backward into the head. There was also a particularly painful spot low down in the occiput. The pain soon passed over to the other side of the forehead where I felt occasional shootings from before backwards. There was a constant pressive pain with every now and then, a shoot, always from the forehead, backward. The whole head was involved, but it was decidedly worse on the right side during the whole course of the proving. During all this time I had a strong sense of nervousness and confusion the latter being especially well marked upon closing the eyes. While the headache was at its height I felt occasional severe twinges of pain, shooting in character, just beneath the right eye, which seemed to involve the supra orbital nerve; there was also pain and tenderness upon pressure here.

The pain continued up to the time I retired at 10 P. M., but was gone when I awoke at 7. My head now felt somewhat heavy and dull, but otherwise I felt as usual until about 11 A. M. At about this time I was taken with quite severe crampy pains in the abdomen, which continued for about fifteen minutes or so, when I had a large yellowish diarrhoea movement containing a large quantity of bile, accompanied by a good deal of tenesmus which soon passed away after it.

It seems to me that we have here a remedy that will prove to be of great benefit to us in the treatment of many of the headaches that occur in nervous women due to nerve tire, or fatigue from whatever cause.

A more extended proving upon many persons with a careful tabulation of the results, may reveal other important spheres of action, among which I think the liver will be found affected to a not inconsiderable degree.

A letter from Dr. Van Denberg of New York State, and a short paper by Dr. J. J. Shaw, of Plymouth, were then read by the Chairman of the Committee, Dr. Wesselhoeft.

DOCTOR M. W. VAN DENBERG'S LETTER.

Your very kind letter of the 1st. inst. has waited two days for an answer. I hoped to find it in my power to reply favorably, especially as I have such a high regard for my Boston brethren, and for the work they have done for Homœopathy.

Were it possible for me to come, I would hardly feel like presenting a formal paper, the ground has been gone over so many, many times. But the fact remains, that we must repeat, review, reassert and re-adjust as the constant changes in the concerts of thought demand. We have not reached perfection, neither has the summit of progress been attained, and one of the signs of progress is change. We are only on the threshold of Homœopathic therapeutics. The great Hahnemann did indeed point the way but he did not live to see realized an ideal *materia medica*, such as he had clearly apprehended in his own mind.

Have a hundred years sufficed to realize his ideal? It seems to me we have made only trifling advancement. We have added drugs and drugs until the bulk is terrifying. But with it all I doubt whether we of today cope any more successfully with the problems of healing than did the doctors of fifty years ago. This is not right.

Having a fixed principle, a plan of procedure, we should have attained a greater degree of perfection than any have reached in the past. We are only abreast with them. What has been done to gather up the pearls of experience and to string them on threads of scientific precision? Almost nothing.

Men of ripe experience die one by one, year after year, and what they have learned goes to the grave with them, and must be all learned over again by those who come after them. This is the way the savages make progress. This method has no part in civilization. This may seem harsh judgment, but does accord with facts, as it seems to me.

Some years ago I proposed in a paper read at the A. I. H. a scheme to collect from the *actual experience* of staunch men the confirmation or rejection of our provings, symptom by symptom, or group by group, as the case might be and to collate by societies, states and finally by the central body, drug by drug, or any certain number of drugs each year, or the whole *materia medica* year by year. There was not a responsive chord. The time did not seem ripe for such work. It will come in the end; it must come. By some such process as this, and by no other, it seems to me, will our *materia medica* become the sure foundation for therapeutic faith which its destiny demands, and of which it has the hope and promise.

With you I deplore the apathy at present so manifest in materia medica. The advances in other lines belonging to the physicians' sphere have been so great—not to say dazzling—that it is small wonder that some branch should lag behind ; and this fate seems to have fallen on materia medica. Some of this is no doubt due to the apathy felt by our confrères in other schools. In Allopathy there has been a steady decline of interest for many years. The text books they now recommend, Hare, Bartholow, Schumacher and what not, are a wonderful retrogression from Stille. But the pendulum will begin to swing the other way after a time. It seems to me it must be at the extreme limit of retrograde in interest now. Perhaps we may be doing something without knowing it to give it a push.

Materia Medica as a Specialty.

BY JOHN J. SHAW, M. D. PLYMOUTH, MASS.

The tendency of medical practice at the present day to split up into specialties, is very marked, and that portion of the medical profession who are still engaged in general practice, especially in the country, are inclined to feel, perhaps not without some justice, that the specialists are getting all the cream of the business. So strong is this feeling in some quarters, as almost to produce antagonism.

One old doctor said to me, "If I were to live my professional life over again, I would have a specialty, if it wasn't anything but corns."

At the New York Post-Graduate College, I found many doctors taking special courses, because as they said, they had got tired of having patients pay all their money to specialists while their own more hardly earned bills remained unpaid.

That the dividing up of medical practice into special departments, is a distinct advance in medicine, no one it seems to me would be likely to deny. The ablest of men can do better work, when they confine their abilities to a limited sphere ; but to expect men of moderate ability to do good work over all the immense field of general medicine, is simply to expect an impossibility. They may do excellent work in some one direction, but probably their whole work will not average anything more than fair.

Homœopathy has attained a standing, an acknowledged position, of which we may well be proud. True it is not yet the dominant school, and many weak-minded people will not employ a Homœopathic physician for that very reason.

Homœopathy's present proud position, (and this, mark you, is what I have been driving at all the time,) is due to the fact that its founders, the fathers of Homœopathy, were all specialists, therapeutic specialists. They were laughed about, or ignored, or defamed, but in spite of all opposition they held grandly on their way, confident and invincible, with nature for their patron.

Why is it that Homœopathic therapeutics as a specialty, has gone out of fashion in this day of specialties? Why have we so few young men who delight to walk in the therapeutic steps of those able men of the past?

There are many young men in the field of medicine, who might distinguish themselves as therapeutic specialists, who will never make surgeons.

If Homœopathy is to hold its own there must be a resumption of the old time specialization of therapeutics. The field is an immense one; the old remedies have not yet been exhausted and new ones are constantly coming into use.

If a few men would each take a single remedy, and give it six months study and application, they would probably become enthusiastic over that particular remedy, and when they reported later, they would create enthusiasm among their hearers.

Again most doctors have some pet remedy which they delight to honor, because it has helped them out of many a tight place. Let them tell us about it.

Homœopathy has done and is doing many wonderful cures not because the doctor uses the shot-gun compound tablets of the old school, or their quick-acting, death-dealing coal tar derivatives, but because there are a few sensible people in the world, who would rather be cured at the expense of a little time, than to be relieved at once, at the expense of their subsequent health or even life, and because there are a few doctors who persist in sticking to good old-fashioned Homœopathy.

Dr. Charles Mohr : I feel highly gratified at having permission to speak before this body, and especially as I am so heartily in sympathy with some of the work you have been doing. If I am not out of order, I want to refer to the *Epiphegus* paper, to say how delighted I am to hear that provings were attempted. We cannot too highly applaud good doctors who prove drugs on their own bodies thoroughly before applying them in the treatment of the sick. It seems to me that is the only proper way. It appears that too great stock has been taken in the last few years in too many drugs, especially of the coal tar and kindred preparations, by the medical profession on the strength of the advertisements and the commercial schemes of pharmaceutical chemists. I think infinite harm has been done to people, even by Homœopaths themselves, by the wholesale prescription of these drugs on the say so of their makers and old school practitioners without careful consideration. This is certainly subversive of Homœopathy. Sorry as I am to confess it, I believe our practice has become degenerate, and it behooves us to look the question fair and square in the face, and go about the work of regeneration. We must come back to the solid ground of our fathers in Homœopathy, and uphold our

therapeutic law. We certainly all believe that *Similia Similibus Curantur* is true. I certainly do for one, and yet I feel sure that much has been done in late years to destroy confidence of profession and laity. But every now and then, as has been witnessed in your papers and discussions to night, we get a glimpse of the fact that the true spirit occasionally actuates our writers and experimenters, and while you may congratulate yourselves that something good has been done by your Bureau of *Materia Medica* this year, how much heartier the congratulations would be, and how much more would be accomplished the coming year, and how much more of interest and real value your report next year would show, if all your members would work steadily and conscientiously in the ascertainment of drug action in health First, and in disease Afterwards, on the scientific principle of *Homœopathy*?

SUGGESTIONS IN REGARD TO THE PROVING OR RE-PROVING OF DRUGS.

BY WALTER WESSELHOEFT, M. D., CAMBRIDGE, MASS.

Whoever would approach the subject of drug-proving in these days of *chirurgico-gynæcological*, electrical, bacteriological and other therapeutics, even in the presence of a *Homœopathic* assembly, can hardly do so without the consciousness of trespassing on the patience of his hearers, and the need of offering some explanation of his officiousness. I do not apologize however, since the chairmanship I have the honor and privilege to hold this evening, is not of my seeking. My reasons for accepting it were no other, than those prompted by the professional consciousness of a serious *Homœopath*, who, however unworthy, is not permitted to shrink from any task laid upon him by the members of this society.

Under a sense of the responsibility of my position, I began early to elaborate a plan, for bringing into clearer view the relationship of our *materia medica*—or rather of some of our best proved drugs—to certain typical forms of disease. As the work went on however, I grew more and more sensible of the instability of the ground on which we are all standing. Therefore, I determined somewhat tardily, to go back once more to first principles, and to ask you to discuss with me, the foundation on which all *Homœopathic* practice must rest—I mean the proving and re-proving of drugs—with a hope and purpose of adapting these more readily, than we can now do, to the indications presented at the bedside.

In the outset, I must prepare you for the regrettable fact, that the modest suggestions I venture to offer, have nothing either new or original to recommend them to your consideration. The subject has

been so exhaustively discussed, that at present, no single individual can do more than attempt to arouse, anew, the interest in it, which shows deplorable signs of flagging, since we are overshadowed by more immediate interests. The literature of this branch of our *materia medica*, as we take it from our Homœopathic journals, and the reports and transaction of our societies, is not as voluminous to-day, as that rapidly swelling mass of non-homœopathic literature, bound up between Homœopathic covers. But I venture the confident prediction, that it is the only portion of our written thought and experience destined to survive in the minds of men the first decade of the coming century. Already there are signs—and no deceptive ones—that the newer therapeutic theories, which during the last twenty-five years, have withdrawn the confidence and the attention of the profession at large, from the use of medicinal substances, are failing to fulfill their earlier promise. Beyond the limits of our school, and sadly crowding in upon these, a new and highly finished pharmaceutical-technique is thrusting into the hands of the willing practitioner drugs in a form and combination which appeal most plausibly to both doctor and patient. The tendency, however, is in the direction of a polypharmacy with which we can have nothing in common, and which, moreover, in the light of past experience and modern scientific thought and methods, is incomprehensible.

As in all ages, and for every conceivable method and measure, clinical experience is once more vaunted as the warrant for the use of two, three and more drugs, skillfully combined in one minute and pleasing prescription; and for a serum-therapy which as yet has little in its favor, save the loudest assertions. And if we contemplate the recent address of Dr. Bantock before the Gynæcological Society of London, the investigations of Dr. Newman, the experience of the late Dr. Tait, and the bewildering disagreement of both surgeons and bacteriologists in regard to the germicide powers of chemical agents, we may even entertain mild doubts as to the efficacy of current methods of insuring asepsis. So much is certain, and meeting with more and more acceptance by modern pharmacologists, that so long as drugs remain therapeutic agents, so long will drug-provings demand increasing attention and so long, too, will physicians be compelled to wrestle with precisely the same problems with which Homœopaths have struggled for a century.

In other fields, we cheerfully concede superiority to those who have enjoyed ampler means of inquiry. Here, we are in advance, so far in advance, in fact, that all others cultivating the same ground have done no more than confirm our own experience and follow more and more in our footsteps. But we do not boast. Despite our progress, the problems which presented themselves to Hahnemann's immediate followers remain unsolved. Something has been accomplished toward clearing the way for their solution, but the methods are far from per-

fect. The diversities of opinion and practice among us, as also the evident grasping at every new preparation and procedure among the great majority of the graduates of our school, sufficiently indicate the need of renewed discussion and redoubled efforts to gain a clear conception of the relation of drugs to those pathological conditions which constitute the indication for their use. It is here that our difficulties center. For although we stand on our law or rule, this is no more than our *theory*. Our *practice* rests on our *materia medica*, and this in its turn on our drug-provings. To the degree, that these are sound, to that degree our practice will be sound, or if you prefer the term scientific.

I am not here to question the soundness of our provings, with these, and with these alone, have we withstood the opposition of ninety years. Whatever of imperfection may attach to the methods pursued in building up our *materia medica*, does not arise from lack of industry, care, self sacrifice and high intelligence—all essentials of scientific experimentation. Nor has there been absence of the most searching criticism. I do not mean that cavilling from beyond our lines so confusing and disheartening to our weaker brethren, but that fearless self-criticism which demands only more exactness and the greater power this must give us. For confirmation of this let me point only to the annual discussions of the American Institute and those of our congresses. Especially would I call your attention to the debate at the Institute meeting of '97 elicited by the papers of Doctors Allen, Price and Sutherland. It appears not to have been within the attention of the Institute to continue this discussion at the following meetings, as I judge from the two latest volumes of the Transactions; but all who are sincerely interested in the elucidation of our principles, the purifying of our *materia medica*, the proving of drugs and the search for clearer indications for their clinical application, cannot fail to regret that the same and allied subjects should have been less prominent in the later meetings.

My own studies have led me no further than the level reached by much abler investigators—those whom I have mentioned and many others. It is now, since our branch of therapeutics has reached the encyclopedic stage, impossible to offer new material, save by the earnest, prolonged and well organized co-operations of many workers, and these I have been unable to command. The utmost I can do is to give the results of a study of methods, and to ask you to traverse with me once more the ground over which many of you have laboriously plodded before. The subject when viewed by the light of today, is so vast, so full of problems and perplexities, that I feel no hesitation in demanding on this occasion, when perhaps, so much new material was expected, a reconsideration of the points still at issue. Our only way to approach the work, in a pursuit of such intricacy as this, is to scan critically that which has been done before. Let me ask you

therefore, to compare briefly with me the older method of drug-proving on which practically all our materia medica has been constructed, with the later ones so loudly demanded by the newer aspects of physiological investigations ; by pathology and diagnosis, or I should say, by the modern methods of exact inquiry. If what I have to say seems as dry and dull as a tale many times told, you must bear with me patiently while I add such comments as I hope may stimulate the interest of those among us who must, if they think to live and strive as Homœopaths, soon take upon themselves the labor and responsibility of carrying on the work.

During the past century, two distinct courses of investigation into the effects of drugs on the healthy organism have been carried on almost side by side. The one begun by Schroff, Jörg, Störk and others, with large and almost poisonous doses, and, carried on later, mainly as purely physiological toxicological investigations, and experiments on animals. With these, we are not now concerned, since they throw practically no light on the problems before us, valuable as they unquestionably are from a laboratory point of view. The other course is that instituted by Hahnemann, and continued by his followers at intervals until the present day. The rules at first laid down in the earliest editions of the *Organon* and retained with some modifications in the latest were framed with the sole purpose of discovering the manner in which drugs could be seen to affect healthy individuals within certain limits—not how much of an effect they could produce in the organism. With this end in view, exact directions growing out of many practical and theoretical considerations, had to be laid down to which it will be necessary to give some thought here. I take them from the fourth edition of the *Organon*, published in 1829, while the founder was still in touch with his followers and before his interest in his original method had given place to the observation of symptoms as they appeared and disappeared in diseases after the administration of medicines in highly attenuated forms. The rules on the whole are plain and founded on that discriminating observation which characterizes all Hahnemann's work. As in the interval between 1810 and 1829 he saw no reason to depart materially from his original conclusions, we may accept them as the outcome of his most painstaking thought and investigation.

Section 105 speaks of the severe secondary effects of poisonous doses ; the less pronounced secondary symptoms of moderate doses, and the absence of all secondary effects of small doses.

In the following section certain exceptions to this observation are pointed out on which we need not dwell.

Section 107 states that moderate doses cause only primary effects.

Section 108. Among these symptoms caused by some drugs not a few appear which are the opposite in character to those manifesting themselves earlier or later or under changed conditions.

Section 110. Among these latter are classed the so called idiosyncrasies.

Sections 111, 112, 113 treat of the fact that every drug produces in the healthy human organism effects peculiar to itself, which although often resembling the effects produced by others, must not be looked upon as identical with these.

Section 114 states in unmistakable terms that in the proving of medicines for their effects on the healthy organism it is necessary to bear in mind that the powerful so called heroic substances cause alteration, in the condition of sound individuals even in small doses. Those acting with less intensity must be taken in more considerable doses, while the least active, in order to produce their effects should be taken only by delicate persons of a sensitive and irritable organization.

Sections 115, 116, 117, give exact directions for the choice of the purest drugs and for the use of but one drug in a single proving.

Section 119 describes the proper condition of the prover who should be in good ordinary health, willing to observe himself closely, and of sufficient intelligence to be able to state and describe his sensations in plain terms.

Section 120. A prover thus qualified by intelligence, willingness and good health, should take for the experiment, before eating in the morning, such a dose of the drug to be proved as it is customary to prescribe in cases of disease ; viz., a non-poisonous dose. This is to be taken in about ten times its bulk of cool water.

Section 121. Should no symptoms appear, the dose is to be taken in double quantity. Medicines should be proved by both male and female provers.

Section 122. Should the first dose produce marked effects, which disappear after several hours, a second dose, greater in amount, should be taken on the following morning, and this failing, a still stronger dose, even four times as strong as the first, should be taken on the third morning. The effects will then appear with certainty.

Section 123. Not all persons are affected in an equal degree by the same drug.

Then follow rules for the observation of primary and secondary effects, the sequence of symptoms, uncertain reactions on the part of the organism, the influence of changing conditions (modalities) and the duration of the experiment.

Section 128. All alterations in health caused by a drug do not manifest themselves in one person, nor always in the same order or degree.

Section 129. The sum of all abnormal changes a drug is capable of producing, can be brought near to completeness only by many observations of many individuals of varied constitutions, and of both sexes. A drug may be said to have yielded all its effects when successive experiments bring forward only such symptoms as have already been repeatedly observed.

Section 136 mentions the possibility of proving drugs on persons with chronic affections ; but declares that in these cases only masters

in the art of observing should be allowed to distinguish between the symptoms of the drug and those of the disease.

Finally Section 138 states clearly and positively that all assumptions, mere assertions, and fictitious symptoms are to be rigidly excluded ; that *everything observed and recorded should be the pure language of nature carefully and consciously interrogated.*

I have as you see given you no more than a most imperfect abstract of a few of the most important rules laid down by Hahnemann for provings and for the observations of results. For this you must be duly grateful as the list is long and much involved. They aim, however, at the fullest knowledge of all the changes a drug is capable of producing ; and although often lacking in precision, and interwoven with assertions and reflections confusing to their meaning, no proving can even today be undertaken without their aid. The greater number if fairly considered and reduced to modern terms present remarkably few points for adverse criticism and will be seen to cover very fully many points of more modern methods.

It is not, in point of fact, the *method* of Hahnemann which has aroused so much opposition to his provings but rather the flagrant departures from it, and more than all else, the results claimed to have been obtained by this method, and the demand that they be looked upon as complete, positive and unerring.

To reject all the results of the older experiments and to demand a *materia medica* built up on wholly new and different methods would be to fly in the face, not only of all Homœopathic experience, but, of the best experience, as well, of many observers from beyond our lines who have again and again confirmed our observations. Nevertheless, the demand for improvement is weighing heavily upon us. It is felt not only in the presence of individual cases as they occur from day to day but in our relation to the drug-provings of the old school and the therapeutic measures based upon them ; in the differences between ourselves, which show no signs of healing ; in the work of our hospitals which turn out annually their favorable reports, without showing distinctly the treatment by which the results are gained ; and most of all, in our schools. What shall be the outcome, if in these seats of learning we continue to be unable to teach our *materia medica* in a form easily grasped by confiding students, or to place in their hands a body of therapeutic knowledge so carefully elaborated as to enable them to approach the bedside with a reasonable assurance of success? Unless we do this, we may never hope to remove from the minds of new generations of doctors that apprehensiveness, which clouds their judgment at the bedside, and prompts them to resort so constantly to every plausible allopathic theory and measure, even in cases most amenable to Homœopathic treatment.

I do not know whether this assurance will follow of necessity from the newer and more exact methods of drug-proving, but there can be

no doubt that it will never follow without them. We know not whither we are going in any course of exact inquiry, but we know that exactness alone can point in the right direction.

The new views and the more searching methods of exact inquiry present not only the nosological classification of diseases, but also the minute changes manifested by pathological processes and conditions in a light wholly different from that in which they were seen half a century ago. As these changes must always represent the indications on which we proceed in the selection of our medicines in individual cases, it is essential that our provings should aim to produce *drug pictures* bearing a more and more distinct relation to them. With this end in view a new plan of proving has been gradually elaborated ; although I am not aware that its rules have been formulated in the terms in which I state them, or accepted either by the American Institute or any other authoritative national society. It prescribes in addition to the majority of Hahnemann's directions certain new rules intended to limit and more clearly define the old ones. They are practically as follows.

1. That all provers subject themselves as an indispensable preliminary, to a rigid examination both by general practitioners and specialists, in order to eliminate at the outset all such symptoms and departures from good health as they may have been unconsciously bearing about with them in daily active life.

2. In order to reach approximately accurate results all symptoms or changes, whether objective or subjective, occurring as the result of a proving, should be passed upon wherever necessary by specialists accustomed to the minute examination of such phenomena.

3. The proving of every drug should be preceded by control-tests with inert substances on every prover. This in order to determine the kind and degree of such symptoms and changes of feeling as invariably appear whenever the consciousness is stimulated in an unaccustomed manner.

4. While physicians are unquestionably the most suitable experimenters, they should be debarred from knowing the nature and effects of the substance to be proved. In this way alone is it possible to guard against many errors arising from self deception.

5. No symptoms or alterations of health should be admitted among the results of a proving which might be fairly attributed to some pre-existing chronic or intercurrent acute affection, while proving is in progress. (Such symptoms or alterations should be excluded even when observed by a master in the art of proving and observation).

6. Since absolutely healthy, moderate and wise provers, such as a faultless proving demands, are not to be found, all provers in their ordinary health should be classified into groups. They should be divided according to constitutional defects, slight habitual ailments, vices, or habits. As for instance, those suffering from nervous, cuta-

neous, catarrhal, and other affections, as also those addicted to alcohol, tobacco, condiments, and similar health affecting agents.

7. In order to make the results of proving valid, there must be found a correspondence, or congruity of symptoms, or alterations of structure and function, among many provers of different ages, constitutions, and conditions of life, as well as of both sexes.

In the modern scheme of provings I can find no concensus of opinion in regard to the doses, or the manner of taking them, but it is very certain that distinct regulations should be framed for the amount of the drug to be used, its repetition, time of taking, and its form. Unless a full agreement is reached on all these points there can be no correspondence of results. In fact, it must be evident to every one who has given studious attention to the more modern provings and reprovings that the arbitrary choice by each prover of the dose, its repetition, form of ingestion and other details, has led to much loose experimentation with needless variation and uncertainty of results. I find, too, that the majority of provings to which I have had access, were conducted by single, or a very small number of provers, and without due attention to any rule governing the length of time during which the experiment is to be continued.

While the majority of the new rules have already worked most important changes in the aspect of our *materia medica*, experience has shown that others are far from practicable, theoretically just, as their demands may be. Dr. Mohr has pointed out, for instance, most forcibly, that the examinations by specialists preliminary to the experiment, raised difficulties almost insuperable, without adding materially to the value of the work. Out of 275 students who were impressed with the need of making provings, and willing to subject themselves to all the requirements, only thirty-four were found to be available, and only four of these could in the end be induced to pursue the course of experimentation in a satisfactory manner. The new rules are far from covering the whole ground; nevertheless, no proving will in future commend itself to the profession that has not been conducted in accordance with the stipulations mentioned.

With the safeguards against error they enforce, experiments made with large, small, minute or infinitesimal doses must command the attention of every one ready to abandon the wholly untried preparations of the modern manufacturing pharmacist.

In furtherance of a movement in the direction of new work, the first question to arise is, What results do we hope to gain by the reproving of our drugs according to the best method that can be devised? Are we in search of countless symptoms with their modalities, or a collection of more or less well defined pathogenic phenomena, in which their objective characteristics shall predominate? Dr. Allen in discussing the means of meeting these indications has declared, that instead of ten volumes of his admirable *Encyclopædia* he would have pre-

ferred a hundred. More symptoms is what he demands. We cannot, he is sure, have too many. I marvel at his hunger, and stand in admiration before his most exceptional powers of assimilation. Other men, even those in fullest sympathy with his views, are forced to condense their practical knowledge of *materia medica* to "tips", or to what has been described in graphic terms, as "arbitrarily chosen congeries of symptoms torn bleeding from their context." All, both the orthodox and heterodox, look with growing apprehension at the redundancy of our *materia medica*. They feel, vaguely perhaps, that Homœopathy has reached its encyclopædic stage, and this we know means stagnation in all sciences. More symptoms, I fear, mean more epitomes, and these mean more "characteristics" and these, in their turn, more faith in authorities, and less of "the pure language of nature faithfully interrogated."

It must be conceded that the rules for proving and observing results must, unless we prove for the sake of mere experiment, follow in no small measure from a preconception of the general character and purpose of the results we hope to obtain. This preconception again must follow from the needs the results are intended to meet, which can be no other than the desire for more trustworthy indications. In other words, we must agree upon what phenomena in any case of disease we intend to bring our medicines to bear. These phenomena constitute our indications, and these in their turn, follow largely from the view we take of maladies. If the clinical objects with which we deal are countless symptoms, arranged and classified according to an arbitrary plan, we must aim above all things to collect the greatest possible number of phenomena. In this case our rules of proving and observation must be adapted to this special end. If, on the other hand, we find in diseases as they present themselves in their clinical aspects, their course and more conspicuous alterations of structure and function, the indications to be met, our rules for proving and observation must be projected on other lines.

The history, in fact the genesis of Homœopathy, and all Homœopathic experience, wherever found, which shows the fullest agreement in method and results, leads to the conclusion that Homœopathic cures follow where a resemblance, not yet sufficiently defined, exists between the pathogenesis of the drug and the more conspicuous features of a pathological process, or condition. Hahnemann did not evolve Homœopathy out of fine resemblances nor did he infer his prophetic recommendation for the use of drugs in diseases he had never seen, from guiding symptoms, characteristics and modalities. He recognized certain concordances of a more general character and not only deduced his law from these, but used them for practical ends wherever he could find them. It is only partially true, therefore, that we are forbidden to prescribe for diseases. We may not use nosological forms or terms with their hypothetical inferences and assumptions as indications, but

it is to be borne in mind, that in many cases pathological lesions of a general or local character run what is called a normal course, in which the variations presenting themselves are wholly insignificant. This is especially true of the infectious and other typical forms of disease, where the type, or one or the other conspicuous changes of structure or function, has suggested the name. The majority of acute and many chronic diseases come under this head. Their local lesions are sure to throw out, as I may say, correlated groups of symptoms, of varying intensity according to the closer or more remote connection of the tissues affected with the central or primary seat of disturbance. The secondary phenomena are the more variable features of the individual cases, but if carefully observed will be sure to constitute the general clinical aspect of what we call the disease. It is this clinical aspect of so many cases, which has served and always must serve, as the clinical indication for a drug. In other cases, it is true, that the peculiar character of a local condition of one or the other of its concomitants has been found, by experience, to constitute the most practical indication for a remedy. But here the local condition is always indicative of a general disturbance having a specific relation to the drug. I need only mention the fine distinctions made by Hahnemann, and elaborated by the new school of dermatologists between the forms of scarlet-fever, and of many other acute and chronic cutaneous affections; the abnormal character of granulations in wounds refusing to heal, and of superficial ulcers. These phenomena and their relationship to certain drugs, as sulphur, arsenic, mercury and others, have been observed again and again by modern surgeons, as well as ourselves, and leave no doubt as to their value as indications. The list might be indefinitely extended to show that it is the more conspicuous, constantly recurring, or typical features of the case, which have served as indications for treatment.

In observing the effects of a drug in an individual we stand before a rapidly vanishing picture of which neither the outlines nor the lights or shades can be easily grasped. To bring these into more distinct relief, the proving experiment must be repeated again and again, not only in the same individual, but in many individuals under varying conditions. If we do this, we shall find that the individual prover is eliminated, and that we are observing a class of individuals who yield in the end a composite picture. This can be studied at leisure in its encyclopædic form with the reasonable prospect of determining its characteristic features. If we see that in the great majority of individual experiments, the drug alters the function or structure of the same organ or tissues, it becomes evident that it is in these, that the elective affinity for this particular substance resides. The next step is the accurate noting of the manner in which the organs or tissues are affected.

The most salient features, then, of this composite picture; those presenting themselves first and with greatest regularity, should be

considered as the outlines. As the experiment is continued, other, less distinctly marked phenomena will appear, more variable in character and of less constant occurrence, but if carefully observed, and recorded in language free from assumption, inference or hypothesis, of inestimable value, as lending completeness to the picture, by giving it that color and character by which it is differentiated from all others.

To determine these distinctions is the most difficult of all the problems of drug-proving, and yet, if we exclude from our pathogenesis all phenomena, shown by the rules already laid down, to be no more than the indirect or fortuitous accompaniments of pure drug effects, much will have been gained in the way of precision. And if we seek in these pathogeneses, thus narrowed down, the relationship of the drug to the more circumscribed clinical pictures of cases, new rules will follow for a practical method of proving, by which a clearer light will be thrown on the operation of our law.

In saying this, I am aware of my departure from established views, and of the objections by which I shall be met ; the objections founded on clinical experience. But the success of one man or even of a body of men, however eminent, with one or the other method of viewing and applying our *materia medica*, or indeed, of any therapeutic method or procedure, cannot and must not be accepted as authoritative.

As yet no sure standard exists by which to judge between a cure and a recovery ; and the absence of such a standard is attributable to the same looseness of individual judgment, which has entered so largely into the observation and recording of drug provings.

One party cries out its successes with every conceivable preparation shrewdly devised and offered by the enterprising manufacturing chemist, or with crude drugs in appreciable and constantly repeated doses, while the other hurls back defiantly its cures with attenuated drugs chosen according to arbitrarily determined indications. The two opposing assertions neutralize each other in the manner of opposing waves of light, and leave the student in the darkness in which he gropes as best he may.

As in regard to the establishment of a better method of proving, my hope is in our more authoritative national bodies, as the American Institute which has done effectual work in harmonizing the standards of our colleges, so my hope is in these bodies for the harmonizing of the work in our hospitals. To establish in these, corresponding methods of clinical observation and record, appears to me to be the only course out of our doubts and contentions.

DISCUSSION.

Dr. Conrad Wesselhoef : Not having read the paper beforehand, it is impossible to discuss it as it deserves, but it needs no discussion for you or me to sit here and listen to it. We observe that the paper has

discussed itself. It has been said here a good many times, and even by the worthy President that, the small number interested in the subject is deplored; I think we have a goodly number present. I am on the side of an intelligent minority in politics and science, and think that the welfare of our Homœopathic Materia Medica rests upon the work of an intelligent minority. As it is, a few workers have carried the great object along with them. There come times, when we miss them, when we have to live upon the works and words, and deeds of those workers. There is an immense amount of work necessary to be done in therapeutics. It seems to me that what we know of medical schools in general is that their work necessarily has to cover so much ground that the subject of pharmaco-therapeutics, that is, the use of medicines, sinks into insignificance; in our school this is only seemingly so, for the work goes on, and I can maintain with truth that medicine pure and simple still has a great future before it; our special system has shown the way for a hundred years in its manner of testing or proving of drugs, and in applying them according to a general law. The question is as to the nature of the work demanded. For my part I am convinced that proving is too difficult to be left entirely in the hands of the inexperienced physician and layman, and that it should be transferred to the expert experimenter and to the laboratory. It should aim at the demonstration, not only of how to produce drug effects *but also how to control them again*, this can be done only to a very limited extent upon the human body, but that of animals must come in to help us out, and the most ardent anti-vivisectionist cannot object to this as long as we are willing to bear our share of discomfort in learning not how to kill, but how to cure. Our provings in the past have been the result of painstaking effort, and what we know of Homœopathy today rests on those provings. Perhaps our fault has been, and is, to be too well satisfied, and to have considered our work done and our system completed.

We realized that, for instance, our pharmacy should rest upon a sounder basis, and as a result we have our Pharmacopœa of the American Institute. Again we may ask: How far does the law of Homœopathy extend? Is it universal? Is it limited and can we find any greater sphere for it than has been found so far? Should we not search for a stronger support for it than the clinical test alone? I think that if we ever want Homœopathy acknowledged as a science, we should, besides believing in it, furnish some more positive evidence based upon direct inductive experimental research. Though we may have proved the superiority of our method to our own satisfaction, we have not quite done so to that of the scientific world at large. For this purpose we have the means now that we did not have a comparatively few years ago—we have them in our now numerous large Homœopathic hospitals and dispensaries. While it is the high aim of these hospitals to cure the sick, another important reason for their existence

is to prove that the practice of Homœopathy is superior to any other method. Do they furnish that proof? A lower mortality list, and lower cost of support of these institutions tells us something, but it does not tell us enough concerning our actual ability to shorten disease nor enough concerning the two different methods prevailing within our own method; nor are we enabled to form a very definite conception as to the value of methods, old or new, in the absence of comparisons between hospitals of different schools and methods.

Hospitals here and elsewhere should publish reports from which even a student might be able to draw correct references regarding the value of methods and our Homœopathic hospital here is now endeavoring to keep its records with greater accuracy and detail with regard to the duration of a case before entering, duration after beginning of Homœopathic treatment, time of beginning of improvement, and duration after beginning of improvement, also with regard to the remedy, its dose, repetition, etc.

When these things are done, then, will we know which method of practice is superior to the other, as far as simple therapeutics is concerned.

Our methods of proving have been amply discussed within the past ten years. And at this point I would make the suggestion that younger writers discussing materia medica and provings, would, before writing upon the subject, read up what has been written in regard to these matters by others within the last twenty years or more; this would save much threshing of empty straw and of useless repetition. It is very important that the proving-methods should be re-examined and improved upon in certain ways. Old provings have established Homœopathy in a manner to satisfy many of us, but they will not be accepted so readily by the rest of the world as valid, until our records of provings exhibit a greater degree of agreement of results, (concordance and congruity) than it has been our custom to accept. The question which the future will have to decide will be upon the maxim that provings, although they may differ in many minor points, should agree in the main. You will, I hope, agree with me that with the consideration of these improvements, with that of pharmacy, as well as with that of keeping our records in hospitals, of demonstrating the law of similars, will greatly aid in placing it upon a firmer basis, will give us work for the immediate future, and above all, give materia medica a start such as it never had before. I am sanguine about it, and should not want to come in here to deplore the confidence in medicines, and the want of enthusiasm on the subject. For my part I have no doubt that the improvements suggested will come about, and that there is a great future before the materia medica, and its application according to a generally recognized law.

Dr. Colby: Really as I look upon it up to about the present time, it seems to me that Homœopathy has been in very much the condition

as the Columbia and the Shamrock—in the “doldrums”; but I think a few such breezes as we have had here tonight would enable us to have a race.

There has been a period in the beginning of Homœopathy which was constructive ; not constructive upon the same plans and with the same rules that we adopt today, not with the same scrutiny, not with the same extensiveness, but they were good as far as they went in their day and generation, and they have been used with considerable success. But after that there came a period of iconoclasm, in which it seemed to be fashionable to decry the work of the fathers, and break up the images, but to set up nothing to take their place. There is an opportunity for us who are at present responsible, to make provings and to know what they mean ; there is an opportunity for us to erect new images, to re-establish our faith, and we want students in science, not undergraduates, but men who have an interest in medicine, and an interest in humanity and its welfare as did our forefathers, and it is our duty to urge them on. Another class wanted very much indeed to make practical use of what we know and what we are going to know. It is not half as easy to do that as to put the principles in practice and demonstrate them and stop a man's ache. That is doing nothing. You can report it as being a specific, but the man who can apply what we know today, provided we could not have any new proving, is the man to be admired.

Dr. Percy :—Said that he considered this subject one of the most important, and assured them that those who are in a position to carry it out realize perhaps more than any others the difficulties in its execution. He gave as an instance, the proving of the drug *Echinacea* last year by a portion of his class, and said that in spite of doses which were large, even physiological results at the expiration of six weeks were entirely unsatisfactory. This year it is the purpose of the class to carry on still further the work of this line, and in that way learn for themselves rather than accept unquestioned the statements of others. This matter not only interests the college and students ; but it interests a body of trained men who are peculiarly well fitted to carry on such experimental research, very many of them being engaged in the study of special branches of medical science, so that every possible safeguard will surround the work. If another year ends without a valuable contribution to drug proving our disappointment will be great. I realize as Dr. Wesselhoeft has said that the subject needs enthusiasm yet I cannot but feel that an excess of enthusiasm on the part of students is not always to be desired. It seems to me that in the beginning they should realize what psychic factors are to be overcome and be on the alert for them. Nothing is so common as self-deception.

Dr. Hiram L. Chase: I am glad to be here tonight. I believe that the pendulum has begun to swing, and its swinging indicates that it is time for us as Homœopathists to again take up Homœopathy. I am an old man, but I remember more than fifty years ago when I first became a Homœopathist that there was some talk of Homœopathy.

I have attended meetings of Homœopathic Societies where I have heard no Homœopathy, and were my eyes blinded I should suppose I was in an Allopathic gathering and very poor Allopathy at that. It is time we had some Homœopathy.

It is time we had provings and reprovings of our remedies. Commence and continue this work. You on your own body can get symptoms which you can get no other way, impressions which are ineradicable. Now I say to you, go back, go back, be Homœopathists and prescribe Homœopathy. I know it is hard work; it means study, it means work, and you cannot do it without study and without work; but if you *do* work you will get results. In the midst of advertised remedies of the Pharmaceutical chemists, you forget your own little quiet dose that will do the work. It was not in the tempest, it was not in the whirlwind, but it was in the still small voice that the Lord spoke: and it will speak now in the voice of Homœopathists.

Dr. Mohr: I have been very much interested in Dr. Wesselhoëft's paper and I would like to speak on one point more particularly, to which he merely alluded. That is in regard to dosage. I believe much discredit has been brought on the Homœopathic school because of the indifference paid to dosage in provings and prescriptions. I believe that when a drug proving is made the dose or doses should be distinctly stated. I believe likewise that the precision as to dosage is essential when drugs are prescribed for the sick. Whether the prover or prescriber uses ten drops of a tincture, or doses of the two hundredth dilution, the records should show the definite quantity. I know how unsatisfactory it was to me when a student, to hear a professor say: "We will give this patient the 30th" of a given remedy; or a patient was given a vial and told to "take some of these pellets every two hours." And I remember well on one occasion, when quite a desirable patient coming from the old school, after consulting one of our physicians was given medicine which was subsequently found lying in the gutter before the doctor's house having been thrown there by the patient as was learned afterwards, because he had been directed to "take a few of these little pills every now and then." That was not definite enough for one unacquainted with the methods and practice of a Homœopathist, and the man who would have been a good patient perhaps, lost confidence in the physician and the school he represented. I think this is really a very important matter, not only to the private practitioner, but still more to the physician engaged in practice in our hospitals and dispensaries. In

these institutions the most careful and exact records should be kept, and I may add that nothing but single, proven drugs should be prescribed. Indifference as to the size and number of doses and times of administration leads to indifference in other important matters, and in the very institutions where the most effectual means are at hand to show the efficacy of Homœopathy, the least good is done and oftentimes positive harm. How often the hospital interne or dispensary doctor simply records of a case: "Dyspepsia and Constipation—Nux," or "Sore Throat—Bell," or "Amenorrhœa—Pulsat." Of what value are such records? Furthermore, indifference as to dose, and a want of study as to effects of larger or smaller doses, frequently leads away from Homœopathy, and gradually there is a drifting towards the grossest empiricism, and finally many a young doctor finds himself in a therapeutic fog, using this, that or the other combination tablet, pharmaceutical product, or proprietary drug without any apparent warrant whatever. Led by reflections, such as these, I was lately successful in having these suggestions adopted in one of our Philadelphia institutions, and since then the records of over 600 genito-urinary cases, every case having all subjective and objective symptoms recorded, and a specific quantity of the single drug given according to the indications, are marvelously satisfactory compared with the vague methods theretofore employed. I claim that we as Homœopaths should seek to induce the workers in our hospitals and dispensaries all over the country to adopt these exact methods of prescribing and recording. How infinitely useful then these institutions would be to medicine. And I have often thought very much of good might be obtained by the general practitioner if our specialists would act accordingly. If the ophthalmologist finds a certain disease of the eye and has done whatever of a surgical or mechanical nature was necessary, he ought to have noted the accompanying symptoms or subjective phenomena, and have prescribed the indicated remedy internally, or to have turned the case over to a general practitioner for such purpose. If this were done by the laryngologist, the gynæcologist, and every other specialist, what rapid strides Homœopathy would make! After a private and hospital practice of twenty-five years, having studied all methods, and duly considered the questions involved in my propositions; having seen the value of drugs thoroughly proven, and the efficacy of the application of such proven drugs in the treatment of the sick according to Homœopathic rules, I am convinced that the general adoption of these methods by all our large hospitals and dispensaries wherever situated, would exert a tremendous influence in spreading the doctrines of our schools. Records would then be invaluable; statistics would mean much more than they do now.

Dr. Wesselhœft in closing the discussion said:—I think in spite of the quiet that reigned in the early part of the evening, that your committee have reason to be gratified at the discussion that has taken place, and at the interest that has been manifested. There are many things that may be said in conclusion. For my part I have felt that what I had to bring before you was largely theoretical and a grave departure from accepted views. I had hoped for a very full discussion, and I almost wish that my paper had been more unfavorably criticised. Nevertheless, I hope the papers of others which have been far more practical, will not fail to make a decided impression upon every one of you, but I feel the need of a strictly Homœopathic spirit here. Dr. Chase who declares himself an old man, but who, if vigor and courage are any signs of age, is one of the youngest among us has spoken in a manner that should leave a lasting impression, as also has Dr. Mohr. What more can you ask if you are doubtful of the course to be pursued, than that a man of fifty years of practice now declares in the clearest manner that what he relies on is Homœopathy strictly used, and what stronger evidence can you desire than that of Dr. Mohr who can show that a comparison between the method of mixed treatment and that which is rigidly Homœopathic is distinctly in favor of the latter.

Adjourned at 10.15 P. M.

SECOND DAY'S SESSION.

The meeting was called to order at 10 o'clock by the President Frank C. Richardson, M. D., and the records of the annual meeting read and approved.

BUSINESS OF MEETING.

Election of Candidates for Admission to the Society.

Dr. Scales moved that the Secretary be allowed to cast a vote for all. Motion was seconded, and became a unanimous vote.

Pursuant to this vote the President announced the election of the following candidates to our Society.

Henry H. Amsden, M. D., Attleboro.

W. Louis Chapman, M. D., Providence, R. I.

Anna B. Davis, M. D., Boston.

Lena H. Diemar, M. D., Cambridge.

Solomon C. Fuller, M. D., Westboro.

Charles T. Howard, M. D., Watertown.

Lucille A. James, M. D., Boston.

Gilbert M. Mason, M. D., Dorchester.

D. T. Percy, M. D., Arlington.

Harry Edwin Rice, M. D., Springfield.
John A. Rockwell, M. D., Boston.
J. Arnold Rockwell, Jr., M. D. Boston.
Alice E. Rowe, M. D., Springfield.
Frank Edward Schubmehl, M. D., Boston.
Geo. F. A. Spencer, M. D., Ware.
Clara M. Sweet, M. D., Springfield.
John H. Urich, M. D., Boston.
George L. Van Deursen, M. D., Lowell.
Frank R. Warren, M. D. Worcester.

Dr. N. Emmons Paine offered the following motions.

Moved:—That the Secretary or other officer of the Massachusetts Homeopathic Medical Society shall include in the transactions of the society, pictures of the members of the society who have died during the year. And further, that the size of the picture, and any question of the inclusion or exclusion of a deceased member's picture shall be decided by the executive committee of the society.

After some discussion this motion was carried.

AMENDMENT OF BY-LAWS.

Moved by E. P. Colby, M. D. To strike out the word "regular" in Art. XXVI line 7, making it read "At all meetings of this Society thirty members shall constitute a quorum etc." As the rule now stands no provision is made for a quorum at a special meeting of the society, which may be called to consider matters of the most serious importance.

Proposed amendments to the By-Laws regarding the dropping of members for non-payment of dues, presented by F. P. Batchelder, M.D.

Art. XXIV. Dues. To add to this article the words—"Members unduly neglecting the payments of annual assessments, after proper notification from the Treasurer may by vote of the Executive Committee be dropped from the roll of membership; special cases mentioned in Article IV, section 1, excepted.

Any person thus dropped shall have the privilege of re-instatement upon action of the Executive Committee and the payment of all arrears."

Article IV. Section 1, line 14.

To insert after the word "pay" the words—"and to drop members for non-payment of dues."

The President appointed the following members a committee to consider the foregoing proposed amendments, and make report as provided in the By-Laws:

J. P. Rand, M. D.; E. P. Colby, M. D.; F. P. Batchelder, M. D.; Carl Crisand, M. D.; F. M. Bennett, M. D.

ORATION.

TWENTIETH CENTURY HOMŒOPATHY.

BY J. HERBERT MOORE, M. D., BROOKLINE, MASS.

Mr. President and Colleagues:—

It is with great diffidence that I stand before you this evening in the capacity of Orator, speaking to the Massachusetts Homœopathic Medical Society. It is with greater diffidence that I announce as my theme: "Twentieth Century Homœopathy." It is by the courtesy of your executive committee, Mr. President, that I avail myself of the former privilege, and which I gratefully acknowledge, and because in common with all honest hearted Homœopathists it is one of my most earnest wishes for the coming century so soon to dawn upon us, that it will witness the general adoption by all right thinking medical men and women, of our therapeutic law as the dominant curative method of antagonizing disease by the use of drugs, that I exercise the latter prerogative in the selection of my subject.

In the progress of all the arts and sciences each generation should show advancement over that of the one preceding, until each department has arrived at that stage of perfection where further improvement is impossible. Such an end seems to have been attained in art, in the exceptional case of some of the old masters, but in the science of medicine, for among the sciences it should be classed, the honest student is only too conscious of the long gap between its present status and this ideal goal. While we thus frankly acknowledge the unsatisfactory state of medicine today judged from this plane of perfection, it is with much satisfaction that we look back upon a century's progress and witness more real scientific advancement in our general profession than had taken place in all the preceding centuries combined.

The closing years of the Eighteenth Century presented in the general medical world the most unsatisfactory condition of medical affairs. Superlatives are in order when it is stated that the most chaotic pathological theories vied with the most chaotic therapeutic measures in the supremacy for first place in the annals of unscientific and harmful medicine, into which it is not my purpose to enter into detail. As it is always darkest just before dawn, so at this time in the first year of the last decade of the Eighteenth Century, light was beginning to come to the medical world through the mind of a German physician then thirty-five years of age. Was his intellect capable of this needed medical reformation, and his manhood and

sincerity such that the medical world would be justified in receiving the light through him?

Would that they had allowed his record up to that time to have answered this question for they would have seen on Easter of 1773 a young man twenty-one years of age, Samuel Hahnemann by name, starting out from his worthy father's home and from Master Muller's private school in Meisen, where the foundation of his earlier education had been most thoroughly laid, to attend the University of Leipsic. In worldly goods he was possessed of thirty thalers for his support the sum total of his patrimony, but his mental stock with his knowledge of several languages can best be appreciated from the fact of his having been intrusted in his twelfth year to teach to others the rudiments of the Greek language. After supporting himself for two years at Leipsic by translating and teaching languages during his medical studies, in order to further the latter he went to the medical school at Vienna where he became a special pupil of Dr. Von Quarin, body physician to the Emperor Joseph, to whose influence Hahnemann always attributed the possibility of his being able to gratify his ambition in becoming a physician. Devoting himself entirely to his medical studies and hospital training, he remained in Vienna until his means were exhausted and accepted through the influence of his patron the position of family physician and custodian of the library of a wealthy baron in the City of Hermanstadt. He so improved his opportunity during the twenty-one months passed in this valuable library that he acquired a most comprehensive knowledge of literature and of the occult sciences, leaving with a masterly knowledge of nine languages to complete his medical course and take in person his medical degree in the University of Erlangen, August 10, 1779.

After practising in lower Hungary, his settlement in Dessau in the spring of 1781 is to be noted as time and place where he first specially directed his attention to chemistry in which he afterwards became one of the most expert authorities. Here he perfected himself also in practical pharmacy with the apothecary Haseler, unconsciously fitting himself for his future appointment of examiner of pharmacies. Enabled to enlarge his practice and thereby his means by obtaining the position of parish doctor he removed to Gommern during the last of 1781, and it was here that dissatisfaction concerning the prevalent chaotic methods of medical practice referred to above, first began to seriously impress his mind. Though he was pleasantly and profitably located with his position of parish doctor in addition to his modest practice, though exceptionally well equipped as a physician and so well versed in all the pharmaceutical methods that he held the position of inspector of drugs in the shops of the pharmacists, nevertheless his dissatisfaction with and distrust of methods of practice became so great, which is so nobly and ably expressed in his later letter to Hufeland in which he writes: "I could not conscientiously treat the

unknown morbid conditions of my suffering brethren by these unknown medicines", that he determined to investigate for himself the whole field of medical practice, and to this end relinquished his practice and spent the following few years in Dresden and Leipsic engaged in Chemistry, Literature and Translations.

It was while translating Cullen's *Materia Medica* during the first year of the decade 1790 that, ever on the alert in his earnest endeavor to be able to improve the practice of his time, he caught his first glimpse of rational therapeutics when he observed that the anti-pyretic power of Peruvian Bark in Malarial Fevers was not due to its astringent nor tonic properties, as this eminent authority supposed, but to its inherent drug principle ; but more especially when he discovered as a result of investigation and experiments based upon this observation, the fact that the action of this drug upon the healthy human organism produced effects very similar to the symptoms of the malarial disturbance for which it was the acknowledged specific. This led him further to investigate whether other drugs producing upon the healthy human organism symptoms similar to those of disease, would themselves be found to be curative specifics for that disease.

It was by no conclusion jumping nor hap-hazard nor hasty deduction that Hahnemann announced his conclusions, for however early he might have been convinced in his own mind, it was not until after six years of thorough research in *Materia Medica* and Toxicology, and of experiments based upon the proving of many drugs upon the healthy human organism, verified by clinical success obtained when prescribed according to this principle, that he first announced to the medical world in 1796 the truth of this therapeutic principle, which he afterwards expressed in his "*Medicine of Experience*" by the formula of *Similia Similibus Curantur*, which was to prove so effective in replacing destructive medicine by constructive methods of safe and sure practice. It is well for the medical world to remember that it was through the columns of the medical journal published by the eminent physician Hufeland, professor of Physics at Jena, that Hahnemann announced these truths, where it may be found in an "*Essay on a New Principle for Ascertaining the Curative Power of Drugs.*"

The following three years Hahnemann remained in Königsutter carrying out in his practice these therapeutic measures, which necessitated from its innovation over the prevailing pharmaceutical methods, his preparing and dispensing his own remedies ; and urging upon his neighboring physicians the advantage of adopting these gentle and more certain measures ; continuing to elucidate the practice of similars in his contributions to Hufeland's journal always manifesting the respect he held for the opinions of his colleagues, however much he might differ with them, always up to this time with gentleness of persuasion and even of entreaty. We should not leave the history of

this Eighteenth Century medicine without briefly noting its closing year, which is important for Hahnemann's discovery of Belladonna as the specific for a severe epidemic of Scarlet Fever which appeared in his town ; for his sudden introduction of small doses ; and for the birth of that unfortunate and unjust acrimony on the part of the dominant school in the early history of Homœopathy, originating in the opposition of those very colleagues with whom he had labored so earnestly and with such conciliation for the truth of the new methods of therapeutics. Unjust because it brought to Hahnemann the most unjustifiable opposition, persecution and obloquy. Unfortunate because it has been of immense disadvantage to general medicine during the past century, inasmuch as such acrimony could not but result at length in embittering Hahnemann towards his persecutors as it would have done in the case of any mortal man, resulting in turn in driving them still further away from his beneficent teaching. In fact the outcome of their opposition and persecution so far estranged his persecutors that they completely closed their eyes and ears to the mighty truth of the Homœopathic Law, which has in turn resulted in a great loss to old school constituency during the past century as evidenced by the success of Homœopathy in combating disease during this period by its specific remedies, made curative by its therapeutic law.

Such unfortunate acrimony on the part of the old school not only kept out of the ranks of followers of the promulgator of a scientific, practical and eminently successful method of therapeutics, the majority of physicians of his generation, but it has been the swiftly running current keeping open the chasm dividing medicine, and has bequeathed to the present old school generation an inheritance of opposition, unfortunately only partly eradicated by the progress of time. Surely ought old school medicine to have had its sufficiency of this unprofessional spirit.

Born of his success in the treatment of that epidemic of Scarlet Fever by a specific afforded by the therapeutic measures they refused to acknowledge, and nourished by the jealousy of his consequent fame this unfortunate and unreasonable opposition had not even reached its full growth when it led these physicians to instigate the druggists to bring suit against him for infringing upon their rights by dispensing his remedies to his patients. Hahnemann ably contested for the spirit of the law in defense of the right to dispense his simple uncompounded remedies not obtained in their shops, but this opposition against him was so strong that he, though a former inspector of drugs, was denied this privilege and notwithstanding the protests of his many patients was obliged to leave the town. Passing over the following six unhappy years of unsettled and intermittent practice due to the activity of his persecutors in opposing his settlement within their territories, armed as they were with such legal enactments, we

find Hahnemann in 1805 located in Torgau in active practice, which his opponents were never again able to compel him to relinquish ; where he remained until his departure six years later for Leipsic, the scene of his successful practice and brilliant teaching of the Homœopathic system of therapeutics.

My apology for having thus hastily reviewed Hahnemann's life up to the publication of the *Organon*, so familiar to you all, is that we might especially emphasize at this time of our entrance upon a new century, the fact : that his record *did* warrant the confidence of the medical world, and an acceptance at least for examination, of the truths he offered : inasmuch as at the time of his first announcing this therapeutic *principle*, as he then styled it, in 1796, history had already revealed in this man of scholarship, one not only of exceptional erudition in literature and languages, but of pre-eminent learning in the physical sciences as well, as attested by his standing as an authority in chemistry both Practical and Medical, in addition to his attainments in the field of general medicine which were of the highest order ; while the subsequent fourteen years of this record, the period of this first announcement of the new principle up to the publication of the *Organon* were occupied, notwithstanding bitter opposition and persecution on the part of his antagonists, in continuous and wide reaching research, in most earnest and effective work in drug proving and in verification of the Homœopathic law in his practice, by clinical results more eminently successful than ever before known in the history of drug giving. In fact they were years of most conscientious and able preparation for his elaboration of the Homœopathic principles and practice based upon the *Law* as he now expresses it, of *Similia Similibus Curantur* which makes up his masterly *Organon* published in 1810.

This I believe to be no exaggerated praise of this book even when viewed in the light of a century's progress, because of the results obtained during this same period by an intelligent application of its essential principles as found in the paragraphs of the *Organon* which make up the heart of this work. An intelligent reader of the *Organon* especially of its explanatory notes will readily discern that it has its non-essentials as well, which, however, have no direct bearing upon these essential principles themselves.

In offering the *Organon* to old school medicine as its first text-book, Twentieth Century Homœopathy does not profess to offer an infallible Bible issued by an infallible Pope, and the Homœopathic profession assures their old school colleagues that we accept none of its teachings and none of its author's sayings which the light of a century's progress demonstrates as untenable. On the other hand we must ask them to remember in their perusal that the book was written a century ago. If its introduction in its denouncement of their practice strikes them as too strong, they should realize that as to its sub-

ject matter they too unite today in equal condemnation of their own practice one hundred years ago. If its literary style seems somewhat vindictive, they must not forget it is but the law of reflex action from their own acrimony toward Hahnemann, which had its beginning eleven years before when he was driven from Konigsutter. However this may be its introduction must impress them with Hahnemann's knowledge of the history of medicine prior to his time and with his references to others before him, to whom *Similia Similibus Curantur* had occurred as a small glimmer of light. As to its subject matter contained in its paragraphs and the theories in their explanatory notes, let us not ask them to accept what we ourselves do not believe, but let us expunge it of its non-essentials.

When we read Hahnemann's wholesale condemnation of pathology let us remember that in his day pathology was in a most chaotic condition, of little use in any department of medicine and perfectly useless at that time as any kind of a basis for therapeutics. When we find its posology too highly diminished, with its dynamization theory, let us remember it was but the historical swinging of the pendulum to the other extreme from the horrible doses of their times, and undoubtedly instigated in part by the hostile attitude of the druggists. When we read of his theory of chronic diseases, let us remember that in his use of the name *Psora*, he referred in a generic but unfortunate term to general skin eruptions as a whole, inasmuch as history assures us he was conversant with the *Acarus* as the cause of local *Scabies*. Let us take his conception of chronic diseases instead of his terminology and give to it the more appropriate term *Dyscrasia*. Let us read his occasional mention of spirit in referring to drug and disease; a metaphorical reference not to things ethereal but to things dynamic. So much for the non-essentials of the *Organon*. In their consideration let us not forget that Hahnemann's teachings were never accorded that honest and honorable discussion to which they were invited and to which they were entitled; such discussion when prevailing in the medical profession rubbing off in time the untenable edges of all new theories and bringing to the front only the positive conclusions. To be sure these non-essentials were promulgated from the same source as were its essential principles which a hundred years have shown to be so firm. So also does the wheat and chaff spring from the same stalk in the fields. Hahnemann has brought forward into practical usage more wheat as regards the curative treatment of disease than all the rest of the reformers of medicine since the time of Hippocrates, and his *Organon* notwithstanding its chaff, is one of the most valuable works abounding in new practices and scientific departures from the deep rut of old medicine which has ever been produced; time has been the winnower, the wheat has been separated from the chaff but the former has not suffered from the presence of the latter, for out of the essential principles of the *Organon*, Hahne-

mann was enabled to bridge the chasm bounded on the one side by curable disease and on the other by curative specific drugs.

And this bridge is no mean structure constructed of piles of palliative measures, which the shifting tide of changing theories will wear away and compel to be replaced by others every decade, as has been in the case of old school therapeutics in the past ; but out of solid masonry has the arch of Homœopathy been constructed, every stone of which is made up of some one of its tenets, each supporting the other, and all locked into place and there supported by the mightiest keystone of them all, upon which we see standing out in bas-relief the formula of our therapeutic law *Similia Similibus Curantur*. Itself supported on the disease side by its foundation stone of totality of symptoms comprising as our second tenet the best method of appreciating disease for the purpose of treatment ; and supported on the drug side by its foundation stone of Proving of Drugs on the Healthy Human Organism, comprising as our third tenet the only reliable method of ascertaining their specific curative power. On the intervening stones we find the remaining tenets of Single Remedy, Preparation of Drugs, Individualizing each case for Treatment and Rule of Dose.

These tenets are the working tools of the Homœopathic physician today as they have been during the past century, concerning which there has always been and is today perfect agreement among the Homœopathic physicians of the world, with the one exception of a small minority who follow the later expositions of Hahnemann concerning strength of medicine necessary for the removal of the disease. When we consider this fact of thousands upon thousands of physicians throughout the world, each thinking for himself, accepting as one man the truth of these essential principles of the *Organon*, we are certainly impressed with the thought that mighty and sure these principles must be, to be followed so unanimously by such a throng. We can demonstrate in only a word the more intelligent prescription of the Single Remedy as proved on the healthy human organism versus compound prescription, because of a definite knowledge of the certain effects the Single Remedy will produce unhampered by the interference of any other drug. We make mention of our fourth tenet the Preparation of Drugs, which is characteristic of Homœopathy, to demonstrate its triple purpose : of arriving at the proper dose of remedy to be prescribed ; of always affording a standard scale for comparison and reference, inasmuch as the proportion of medicinal to non-medicinal substances remains the same with each remedy ; and especially serving the purpose of resolving the drug into a condition whereby it may be best assimilated by the diseased tissue, a method so practicable that it is in universal use among Homœopathic physicians.

Let us now proceed to demonstrate to the coming century of medicine the practicability of our method of appreciating both disease and drugs for the purpose of establishing their specific curative relationship, before we speak of our therapeutic law which constitutes the very essence of this relationship. In demonstrating the practicability of our method of appreciating disease by the Totality of symptoms for purpose of treatment, we shall be able to brush away a cobweb of misapprehension which has existed in the minds of our old school colleagues, concerning the attitude assumed by Homœopathy towards Pathology, which has been a point of attack against our school, for it has been asserted that the Homœopathic physician has little knowledge of and little use for this branch of medicine. Nothing is more erroneous for a knowledge of the facts and theories of what constitutes the best and generally accepted Pathology of the present day is essential to every scientific physician irrespective of school of medicine, before he can become a master of either diagnosis or prognosis, the lack of which precluding the name of a thorough physician. Thus far is the road travelled in common by physicians in both the old and new school. This granted, which reason is bound to do, it is when we approach the question of treatment that the paths begin to diverge, for herein lies the difference: in our not accepting Pathology as the only one prominent safe basis upon which to found the treatment of disease, as has been the case in the past history of old school therapeutics, when in consequence of its shifting pathological theories each decade has had its theory of treatment only to be condemned and avoided in the next. The Homœopathic physician on the other hand, takes this branch of medicine for what it is worth, and while he utilizes it so far as its known facts are concerned, for discrimination concerning the nature and progress of disease, he does not make Pathology the only reliable basis of treatment. He is not obliged to possess an unerring Pathology on the one hand, nor an erring pathological theory on the other, in order to perform his greatest duty as a physician, that of curing his patients. It is the whole range of positive Symptomatology rather than—many times blind and negative—pathology alone that forms the safe foundation of appreciating disease for Homœopathic treatment.

With this end in view he avails himself of all the presenting symptoms, not only those perceptible to his unaided senses, but when necessary calling to his aid measures common to the several branches of medical science, stethoscope, microscope, opthalmoscope and all the rest, in order that he may in this way thoroughly acquaint himself with the disease, and what is more, with the disease as it exists in each individual patient; resulting in that method of individualizing each case, a practice peculiar to Homœopathy, since this system alone gives predominating place to consideration of individual symptoms in applying drugs to disease. Is not this a superior method of

thus acquiring a perfect picture of the disease as it exists in each individual patient, by utilizing the very instruments which nature affords us in the symptoms of disease and which we have always before us, presented to the discriminating physician as the truthfully reflected image of what is otherwise often obscure and without the range of our positive knowledge? Is not this superior to a method obliging one to concentrate the attention upon the pathological condition alone, and to decide upon its true nature which oftentimes is impossible, before one can intelligently direct any curative medicinal treatment against disease? If Pathology fails the old school physician he is necessarily at sea so far as intelligent treatment is concerned, for with him pathology is a *sine qua non*, and to him individual symptoms and totality of symptoms have little meaning.

On the other hand while not solely dependent upon it, Practical and Scientific Homœopathy has use for Pathology in its Symptomatology of disease for purpose of drug treatment, and the extent to which it will be applicable in the coming century will depend upon how far it may be relied upon as an exact factor in the study of disease. This is as it should be, for the pathological condition as regards the application of medicine to disease is to the Homœopathic physician an additional indicator pointing to the selection of drugs, usually especially serviceable in indicating the proper group of drugs, from which the totality of symptoms proper will positively indicate the individual drug. Hence it is practically but one other manifestation of the disease which with many others, go to make up the totality of symptoms calling for drug action. Consequently if Pathology fail the Homœopathic physician he is inconvenienced concerning an intelligent application of medicine to disease only to this extent; for but one star out of the many has fallen from the firmament of Totality of Symptoms. Having thus proved that the most reliable method of appreciating disease, for the purpose of medical treatment, is by recognizing the totality of symptoms from the most individual symptom on the one hand, to the pathological condition itself, whenever this is positively known, so it is in the case of drugs. Homœopathy has always taken this stand, that the most reliable method of ascertaining the individual curative virtues of drugs is by proving them upon the healthy human organism, and as in the case of the disease so in the case of the drug, its action upon the healthy human organism so far as a correct appreciation of its curative virtues is concerned, is made known to us by the totality of symptoms; and just as in the former case the pathological condition was not essential but made up, when present, one toward the totality of symptoms of disease, so in the case of drug proving, the pathogenetic condition itself instead of constituting the only action of that drug, merely goes to add one more symptom toward making up the totality of drug effects upon the healthy human organism.

Let us now consider the question of dose. When Hahnemann promulgated his reform in therapeutics and prescribed drugs specific to

disease, he at first prescribed them in such doses of the times as he had been accustomed to, but soon found that though they were ultimately effective, the patient was first greatly aggravated as to his diseased condition. With his accustomed intuitiveness he reasoned it was because of the too powerful dose of medicine directed against the diseased and thus over-sensitive part, that the disease was aggravated. He then conceived the idea which was strengthened by the fact that improvement ultimately followed notwithstanding immediate aggravation, that if he could diminish the size of the dose so that improvement might at once follow without the intervention of this aggravation, he would arrive at that strength of medicine requisite for the accomplishment of thoroughly antagonizing the disease without at the same time aggravating presenting symptoms or creating extraneous ones.

This is practically the dosage of every paragraph of the Organon, and so far, the Homœopathic profession follows Hahnemann as regards dose; for this is the practical and scientific rule of dose with the great majority of the rank and file of Homœopathic physicians, governed by the nature of the disease, the nature of the drug and the nature or susceptibilities of the patient; which rule of dose I shall phrase as: That strength of medicine which administered in proper form and at proper intervals will thoroughly eradicate the disease, without aggravating presenting symptoms or creating extraneous ones.

I am very much in earnest concerning this question of dose and the misunderstandings concerning it which are pregnant in the minds of the old school profession, and of the laity not in sympathy with us; because I believe that the unnecessarily minute dosage which has been a fact in the posology of Homœopathy is responsible for their mistaken idea that Homœopathy signifies merely a school of weak doses of medicine, cold water, little pills, easy to take, good for children and all other such nonsense, which has led them to believe however, that there has been little or no efficacy in the medicines administered by Homœopathic physicians. The excessive dilution of medicine beyond the necessary point indicated in this rule of dose, I believe has been one of the greatest obstacles in the way of the acceptance of our therapeutic law by old school medicine. So long as the dose is kept within the domain of reason, and of science which at present recognizes infinitesimal divisions and that they are of potent activity in many instances outside of drug action, we can demonstrate the practicability and in most cases the necessity of small doses; because of the fact that our therapeutic law prescribes drugs to act directly upon diseased and thus over-sensitive parts.

When we go beyond this domain of reason and of science and attempt to uphold the minute dosage beyond them on no other plea than that of experience, and that too of experience in chronic cases,

we shall find the twentieth century too abounding in instances of purely mental therapeutics to allow of the argument of experience beyond certain demonstrable lines ; even though that experience of untenable dosage is bolstered up by theories of dynamization which very few practical men are able to accept. The writer believes again that excessively minute dosage is the predominating if not the sole objection to our school of medicine among the laity, and not because they question the practical or scientific truth of our therapeutic law concerning which they know but little. Should not our position in the coming century assume that of a more educative one, in order that we may dispel this mis-apprehension of no efficacy in Homœopathic medicines, and in order that we may emphasize the importance of our law of cure, that they may see it is *Similia Similibus Curantur* which makes up the bone and sinew of Homœopathy and not the subsidiary question of dose. Inasmuch as we already have a practical and scientific law of cure, let it be the chief aim of our school of medicine, so far as dose is concerned, to place Homœopathic Posology of the twentieth century upon such a scientific and reasonable basis by means of systematic and accurate research, that we may be able to demonstrate that the use of medicine as regards the strength of dose by all Homœopathic physicians is as reasonable, as scientific and as practical as is the law of therapeutics by which the remedies are selected.

After this has been accomplished, the proper territory of Homœopathic Posology mapped out and its limit fixed, then if beyond this, any physician or class of physicians may choose to take up the question of extent of divisibility of drug matter, for the purpose of ascertaining to what an extent drugs may be diluted or divided and still retain any of their original substance, or to what an extreme extent they may be so diluted and still produce any effect whatever upon the organism in health or disease, theirs is the right so to do; but let them undertake it merely as a question of investigation and one divorced from Homœopathic Posology, and not with the purpose of upholding unproved and indemonstrable conclusions which will only barnacle Homœopathy with an untenable Posology which will continue to impede and prevent the general acceptance of its law of cure. Standing thus upon this positive, but liberal and democratic ground concerning the question of dose, twentieth century Homœopathy must refuse to be bound by any links to any system of unnecessarily minute dosage, and in fact of any minute dosage beyond that necessary for the fulfilment of this practical rule of dose, which to emphasize I repeat: That strength of medicine which administered in proper form and at proper intervals will thoroughly eradicate the disease, without aggravating presenting symptoms or creating extraneous ones.

This brings us to a consideration of our therapeutic law itself, which together with these other tenets make up our system of therapeutics

which is called in deference to the pre-eminence of its law among them by the name of Homœopathy, which we define to twentieth century medicine as: The Science of Therapeutics which acknowledges a specific relationship between disease and drug action embodying as its principle of drug action the therapeutic law of *Similia Similibus Curantur*, and employing in the selection of drugs for the cure of disease this same therapeutic law expressed in its injunction *Similia Similibus Curantur* as the means of ascertaining what particular drug bears this relationship to the given disease. This formula, which in its indicative mode, translated "likes are cured by likes," declares the basic principle of specific curative drug action, and which in the injunction of its subjunctive mode affords us as it does a sure guide pointing directly to the proper remedy to be selected for the cure of a given disease, must certainly indicate a reliable keystone in the arch of our Homœopathic therapeutics.

The pith of this formula expressed in its working clothes *Similia Similibus Curantur*, and in the King's English "let likes be treated by likes," signifies that diseases to be cured by drugs, should be treated by remedies which produce upon the healthy human organism symptoms most similar to those of the disease, and practically teaches us that whenever we have on the one hand a disease presenting certain manifestations by which its presence is indicated, inclusive of the pathological condition itself whenever positively indicated, but always and especially making use of the signs of the disease which are always appreciable—the symptoms proper of the disease which are always before us; and whenever we have on the other hand a drug whose inherent action which nature has given it produces upon the healthy human organism drug manifestations (from the pathogenetic condition itself to the symptoms proper of its drug action), most similar to those of the disease; then are we able to eradicate the disease by administering this similarly acting drug.

Although we may be unable as yet to follow throughout, the working of this therapeutic law in that we cannot as yet indisputably demonstrate just how this eradication of the disease is brought about by the similarly acting drug, we are, however, able to follow the steps of its *modus operandi* sufficiently far to enable us to claim for it a scientific and reasonable basis: inasmuch as we *do* know that the Homœopathically curative drug as soon as administered, in response to its elective affinity selects out and acts directly upon the diseased part, and because of the similitude between disease and drug action produces upon the diseased part medicinal impressions which *do* eradicate the disease.

No theory of explanation of this one fact of just how the similar drug impressions eradicate the disease, has been advanced which has received a more general acceptance than that originating with Hahnemann which is essentially as follows: The similar drug impressions

eradicate the disease on account of the impossibility of the co-existence of the two similar disease and drug impressions upon the same part ; and it is the drug which displaces the disease rather than vice versa, because of the stronger affinity of the drug for the part inasmuch as drug affinity for a part is always stronger, though the drug impressions are more transient and more easily eliminated than in the case of disease ; the natural disease is thus eliminated, subsiding as it were for want of territory to act upon, because this territory which it originally affected in response to *its own* elective affinity, is now occupied by the similar drug impressions ; the vital action of the part having been embarrassed by the presence of the natural disease, now liberated as the disease is being displaced by the drug impressions, its reaction is established, the remaining drug impressions are eliminated and the normal condition of the part is restored.

Whether or no this explanation of the *modus operandi* of the similar drug at this particular point shall prove correct, this much is one of the few certain things of life ; that the law itself is practical and affords most practical results in its working, as evidenced by the superior success which follows in every day experience the use of drugs in disease, selected according to this law ; and as evidenced by the fact that Homœopathy has brought forward during its past century's existence more specifics, and by specifics I mean single curative remedies which cure rather than merely palliate disease, than the old school has discovered in all preceding centuries ; and that too in the not exaggerated ratio of one hundred specifics to the credit of the Homœopathic School to one specific to the credit of the old school.

In this definition of Homœopathy as a similar specific relationship between disease and drug action, we have one that not only defines but assigns to its proper place in future therapeutics this law of similars, for whatever method of future therapeutics may be brought forward that shall prove successful in eradicating disease, it must be founded upon a closely affiliative relationship between the disease and the action of the remedial measure whatever that measure may be ; as has already been attested outside of drug action by the clinical history of Vaccination and Anti-Toxine, both of which the writer believes will be further demonstrated as acting in accordance with the law of similars—if not *exactly* as do similar drugs over similar diseases because of the difference between the character of their own and of drug essence, at least in accordance with the general character of the therapeutic law of similarity.

Whenever this specific curative relationship is brought about by the use of drugs—with which Homœopathy has heretofore been concerned—it is demonstrable that it is not by their Antipathic action (the pure Antipathic action of drugs, by the way being very rare), for this action when used in the treatment of disease proves palliative rather than curative ; neither is it by their mechanical, chemical or

any other Allopathic action, drug effects which in the presence of disease of any duration are temporary rather than permanent, palliative rather than curative ; but when this specific curative relationship is brought about, it is demonstrable that it is by the Homœopathic action of the drug from the fact that such similar action always proves curative. For this reason Homœopathy acknowledges and employs *Similia Similibus Curantur* as its working principle of drug action, and for this reason *Similia Similibus Curantur* will continue to be the curative method of treating disease during the coming Twentieth Century as it has been in the past ; and this law of similars will be applicable whenever disturbances or diseases are of such kind or condition as to make practicable the establishment of this specific curative relationship and whenever we have in our possession that proved drug whose drug effects allow of such selection.

An intelligent observer will appreciate that this limitation conduces to the strength of Homœopathy, not to its weakness: to an enlargement of its opportunities for curative action, not a lessening of its prominence in the therapeutic field—for by no law of nature is the most effective results obtained, unless properly harnessed and intelligently bitted within the limits of its own special sphere. The experience of many thousands of physicians throughout the world in their clinical success with the law of similars ; comparative clinical results ; its scientific and practical application, all testify that in the coming century as in the past the great majority of disturbances and diseases will come within this sphere of Homœopathic curative specific drug treatment.

This leads to the question of the position to be taken by the Homœopathic physician as a prescriber in the therapeutic field for those cases which do not come within this domain. And colleagues, that there are such cases in the wide field of the physician's practice must be acknowledged by even the most enthusiastic believer in Homœopathic therapeutics, of whom the writer counts himself an humble one. Let us define this position by what is implied in the recent resolution adopted at its last session by our American Institute of Homœopathy, which reads "I define a Homœopathic Physician as one who adds to his knowledge of medicine a special knowledge of Homœopathic therapeutics. All that pertains to the great field of medical learning is his by tradition, by inheritance, by right." It would be an inconsistent physician who, claiming a right to this knowledge and resource of general medicine, did not aspire to obtain them. It would be an unwise and narrow physician who would refuse to apply any therapeutic measure at his command, should the best good of his patient demand the same in any case which lay outside the domain of Homœopathic drug giving.

Should this necessity occur within the sphere of curative affinitive relationship between disease and therapeutic measure—or in other

words the sphere of the Homœopathic law—and some other agent be proved superior to drugs, the same should be employed. Should the Anti-Toxine treatment of Diphtheria fulfill its expectation of proving superior to drugs it should be used whatever the method of its action; though the writer believes in this case the Homœopathist does not practically depart from his law of cure—merely a change of instruments: Anti-Toxine instead of Drugs. Further bacteriological discoveries will only confirm the truth of the law of similars as the *modus operandi* of the therapeutic method by which toxine diseases are eradicated by their curative anti-toxine agents. It is already demonstrated that the disturbances of the organism in the presence of germ diseases are not due to the germs themselves, but are in consequence of the poisoning by the toxins resulting from the germs; and as it is in the case of drugs, so in the case of anti-toxines—it is in disputing with these toxins their action upon the organism that the Homœopathic principle will do most effective work.

Should this necessity occur on the other hand in any case lying outside the domain of similar specific relationship between disease and drug action, and the mechanical or chemical, the antipathic or any other palliative action of a drug is demanded by the best good of his patient as a temporary expedient, the same should be used. Thus equipped in the knowledge and resources of general medicine in common with his colleagues of the older school, reinforced *in addition* by the far more important resources of the Homœopathic system of therapeutics so far as the cure of the great majority of diseases is concerned, the Homœopathic physician takes his position first as a general physician qualified in the performance of all the duties of the physician pertaining to all the branches of medicine, and he further and as *an addendum* takes his position in the capacity of Homœopathic physician, as the scientific and practical therapist of the Twentieth Century.

Thus entrenched, the Homœopathic profession in their belief of the irrefutable efficacy of their system of curative therapeutics, convinced that the old school profession owe it as a duty to their patients that they not only acknowledge, but acquire and apply in their practice the Homœopathic action of medicinal substances, offer and urge upon them, as our Nineteenth Century's bequest to Twentieth Century medicine in exchange for the results of their good work in Pathology and Bacteriology which we are glad to recognize and to employ—we offer this therapeutic law of *Similia Similibus Curantur* as the practical and scientific method of eradicating disease by specific curative drug action. That the old school profession is in need of our therapeutic law and of our specific remedies which as an outcome of this law are found in our system of curative therapeutics, inasmuch as they have had no law nor even principle of drug action that has led them to a curative therapeutics, but devoid of this, having in its place a system

of merely palliative therapeutics so far as the use of drugs is concerned—that their profession is in such need is evident from the fact that in contrast with their excellent work on the disease side of the picture during the past century, their therapeutic *curative* work during this period with the single exception of Toxine treatment has been nil, leading to that unsatisfactory do-nothing method of therapeutics known as expectancy which is so evident in their standard works on practice of medicine, and in the therapeutic teaching of their medical colleges.

Witness the corroboration of their therapeutic position and need, which has recently appeared from old school sources. I quote from a recent editorial in one of the leading old school journals—The Philadelphia Medical Journal page 989 entitled “A National Therapeutic Association.”—“To cure his patient is the physician’s function or business in life. All other parts of medical education are preparatory or auxiliary, and yet there are medical organizations of every kind, and devoted to all the subordinate branches and all the specialities of medicine, except to this chief one of therapeutics. This fact seems unaccountably strange, and its unfortunate results are painfully evident. Some journals have made a desperate and not remarkably successful attempt to find some compensation for this therapeutic chaos by instituting departments in experimental or practical therapeutics ; but, as a rule, the lay commercial manufacturers and agents are doing nearly all the work of any value in this branch of investigation. Some of it has been most commendable, and, of course, much of it is scientifically without value, not a little being false and pernicious. It is at least unsystematized and without authority ; at its best, it emphasizes the pertinent question, why should a work of such profound importance, the very primal duty of the medical profession, be left to non-professional men ? We have learned that this somewhat shameful condition is being recognized, and that a movement may be started to organize a national therapeutic association, and we trust that it may be speedily realized. The best scientific men of the country—physicians, pharmacists, and chemists—should take an immediate and active interest, and endeavor to establish the organization on a durable scientific and ethical basis. If this be done, it must be of the utmost benefit to professional progress.”

We ask the Old School to contrast this their unfortunate state of therapeutics with the scientific and practical status of Homeopathic therapeutics, and remind them that this chaotic condition of their therapeutics was recognized and condemned by Samuel Hahnemann over one hundred years ago ; from their unwillingness to acknowledge the justness of his criticism though based upon unusual medical insight and knowledge, and from their refusal to co-operate with him in any way for the betterment of this unfortunate condition, there resulted

the birth of the Homœopathic school of medicine which *has* devoted its special attention and directed its best energies to the improvement and advancement of therapeutics, and best of all, of curative therapeutics ; resulting in the promulgation and clinical demonstration of a law of curative drug action, which, in turn, has resulted in bringing forward very many specifics for the various phases of disease.

Such having been the life work of the first century of its existence, Twentieth Century Homœopathy in a spirit of conciliation, but with the spirit of justice demands of the Old School of medicine a recognition and acknowledgement of its precedence and standing in the realm of specific curative therapeutics. We need have no fears but what our colleagues of the older school would receive this—our therapeutic law if only their prejudice might be removed sufficiently long to allow of an unprejudiced examination of its true merits. "*So mote it be.*" If they ask for proof we point to its successful clinical results, in consequence of which it has so effectively withstood the test of a remarkable century of scientific progress, in the face of which it would have downed were it not what we claim for it. If not content with clinical proof we point to the fact that already is our law of similars being unwittingly demonstrated by the scientific experiments of their own physicians in the Pharmacological Institutes of the old world ; so interestingly portrayed by Dr. Deschere in his comments upon their Pharmacology of the Camphor group in his discussion of our honored colleague's paper—Dr. Conrad Wesselhœft—at the Detroit Materia Medica Conference 1896. To quote from Dr. Deschere : "Experiments with like results are constantly being made by physiologists with all possible drugs many of which are in daily use by the Homœopathic profession, and they show their unswerving obedience to the law of similars with almost mathematical precision."

Let us hope that in the coming century this good work will go on and let us not leave it to the old school physicians alone to demonstrate in this experimental way the truth of our law of similars, with their misinterpreted explanations of such similar action ; but as we were the means of first demonstrating and promulgating its truth, and have repeatedly verified it by most convincing clinical results, may the Homœopathic profession endeavor in the coming century to place our therapeutic law upon an as irrefutable basis by demonstrable scientific pharmacological research, as it has been placed during the past century by demonstrable and irrefutable clinical results. Let us do this by responding through our college laboratories and hospital records, encouraged by our state and national societies, to Dr. Wesselhœft's plea for such scientific demonstration to be brought about by his "Inductive Experimental Research."

REPORT OF THE COMMITTEE ON SURGERY.

HORACE PACKARD, M. D., Chairman.

- I. The Differential Diagnosis between Appendicitis and Inflammatory Affections of the Right Ovary and Tube. H. P. Perkins, M. D., W. Newton. Discussion: Alonzo Boothby, M. D., Boston. F. A. Hodgdon, M. D., Malden.
- II. A Case of Double Hare Lip. Illustrated. Carl Crisand, M. D., Worcester. Discussion: Geo. B. Rice, M. D., Boston.
- III. Movable Kidney with Report of a Case. G. Forrest Martin, M. D., Lowell. Discussion: J. Emmons Briggs, M. D., Boston.
- IV. The Importance of Correctly Diagnosing Injuries to the Head. W. Louis Hartman, M. D., Syracuse, N. Y. Discussion: N. W. Emerson, M. D., Boston.
- V. Fracture of the Patella. Geo. E. May, M. D., Newton Centre. Discussion: Winfield Smith, M. D., Boston.
- VI. The Surgical Treatment of Salpingitis. Geo. R. Southwick, M. D., Boston. Discussion: Walter Wesselhœft, M. D., Cambridge, Sarah E. Sherman, M. D., Salem.
- VII. Osteomyelitis. Charles H. Thomas, M. D., Cambridge. Discussion: J. K. Warren, M. D., Worcester. F. A. Gardner, M. D., Salem.
- VIII. Good Health Without a Gall Bladder. F. A. Hodgdon, M. D., Malden. Discussion: W. F. Wesselhœft, M. D., Boston.
- IX. Non-intervention with the Knife in Appendicitis. Elmer H. Cope-land, M. D., Northampton. Discussion: F. B. Percy, M. D., Brookline. Horace Packard, M. D., Boston.

THE DIFFERENTIAL DIAGNOSIS BETWEEN APPENDICITIS AND INFLAMMATORY AFFECTIONS OF THE RIGHT OVARY AND TUBE

H. P. PERKINS, M. D., WEST NEWTON, MASS.

The subject of this paper was chosen by the Chairman of this section as being of interest to many of our members, but in presenting the paper I ask your indulgence as to its scope. It is not an exhaustive essay to which the fellows have either time or patience to listen. In the briefest possible limits I hope to show what diseases of the right tube and ovary are commonly mistaken for appendicitis and to determine what points, if any, we can rely upon to assist in diagnosis. The possibility of mistake is not rare. In a very valuable article, Fowler of Brooklyn has shown more than twenty forms of simple and conjoined disease of the right adnexa and appendix in which the diagnosis was incorrect. Primarily, appendicitis is more apt to be

mistaken for disease of the tube than such trouble for appendicitis. This fact hinges on what is practically an axiom—that in medicine as in other pursuits one naturally looks for the expected. The normal or abnormal woman being more prone to diseases of the appendages than of the appendix, in doubtful forms of inflammation the physician chooses the most likely.

Let it be understood that we are now dealing with those cases in which there is no doubt, for in the majority of cases in women as in men the diagnosis is fairly easy. Given the sudden onset, the digestive symptoms with the pain, tenderness and rigidity well marked in the region of the line running from the umbilicus to the Ant. Sup. Sp. Proc. the condition is evident.

A short glance at the topographical anatomy of the appendix, with its normal and abnormal relations, reveals the reason of uncertainty. The appendix may lie in various positions in the abdomen—above or below, in front of or behind the cæcum ; transversely across to the left side of the cavity or at an angle across. In over 90% of all cases its normal base is found within a circle of $1\frac{1}{2}$ inches in diameter external to the rectus on the line drawn from the umbilicus to the Ant. Sup. Sp. Proc. The meso-appendix reflected from the mesentery of the ilium, has in the female a prolongation running to the ovary bringing it at times nearly in apposition to that organ. Through this appendicular-ovarian ligament an extra supply of blood is carried to the appendix, and in its folds a chain of lymphatics has been demonstrated giving direct communication with the ovary and aiding the possibility of infection.

With the appendix of its normal length of from $2\frac{1}{2}$ to 3 inches, in most cases the pus of its inflammation lies in the region external to a line dropped from our first line to about the center of Poupart's ligament. The appendix being of abnormal length running over the brim of the true pelvis, the pus may be found in various parts of the basin, even invading the folds of the broad ligament or the pouch of Douglas.

It is thus seen how intimate is the relation of the tube and ovary to the appendix and how the territory of the former may hold the inflammatory products of the latter.

The morbid conditions of the adnexa which are liable to cause trouble in diagnosis in view of the possibility of abnormal locations of the appendix, are :

1st. The various forms of tubal disorders, catarrhal, and purulent, pyo-salpinx, hydro-salpinx, hæmato-salpinx, and tubal pregnancy.

2nd. Inflammations of the ovary congestive or cystic. In catarrhal salpingitis, we have increased temperature and pulse range, nausea, vomiting and abdominal tenderness, with paroxysmal pains ; all of which symptoms being likewise characteristic of appendicitis. But there are points of difference. The pains are paroxysmal and not the

colicky ones of appendicitis. Happening at or during the menstrual period, the flow is likely to cease; if in the interval, there is frequently a bloody vaginal discharge. Painful micturition is common; rather unusual in appendicitis, but has been noted. The nausea is apt to persist during two or three days. There is seldom any localized abdominal pain. The rigidity of the abdomen is not well marked. By vaginal examination early in the course of the disease the tube will be found very tender and the pain will be increased by lateral movements of the uterus. With care in the estimation of the value of symptoms there should be no mistake.

In purulent salpingitis—the pachysalpingitis of Mundé—whether a later state of the catarrhal trouble or the early stage of an infective—the same subjective symptoms present themselves with possibly a still higher range of temperature and usually a chill. By vagina the very tender tube can be made out early. Fluctuation can not be detected. With *pyosalpinx*, which in its mild or severe form is one of the most common forms of tubal trouble, appendicitis has many points of resemblance. There is frequently a chill with nausea and vomiting, abdominal pains and tenderness, with fever and rapid pulse. The pain is paroxysmal, apt to radiate into the thighs, and is not referred to the umbilicus or stomach, as is common with that of appendicitis. In the beginning of salpingitis there is seldom tympanites and little rigidity of the right side. One observer has noted that the abdominal reflex is much lessened in appendicitis but not much affected in early stages of salpingitis.

By the vagina the dilated tube is easily felt at the beginning of the disease. If the trouble is unilateral the uterus may be pushed to one side; if it is bilateral the diagnosis is simplified. The tumor is close to the right horn of the uterus limiting its motion; lateral motion causing severe pain. The tumor is painful to the touch, and semi-fluctuating. Where the appendix extends into the true pelvis the tumor of appendicitis is seldom felt by abdominal palpation. Remembering, too, that it rarely develops before the third day the early vaginal examination assists us. Except it should invade the folds of the broad ligament or the pouch of Douglas late in its development, its abscess is seldom felt here. The rectal examination may also help to confirm an opinion. In most cases however, its evidence is more negative than positive.

Barring the complication of septic conditions, salpingitis is usually sub-acute, or chronic with exacerbations; as a rule appendicitis is acute.

In all these cases, the history of a previous gonorrhœal infection gives a decided clue. Having a case of such past infection, with leucorrhœa, disordered menstruation and old pelvic pains, developing acute or sub-acute symptoms such as just described, the diagnosis is made easier.

Deaver believes that he is sometimes helped in doubtful cases by finding evidences of renal hyperæmia—albumin, casts, and free blood globules—which he regards as commonly present in appendicitis.

It must be outlined in this resumé that the subjective symptoms of these two conditions have much in common, varying in degree more than in kind, and that reliance must be placed only in the objective development.

Moreover, in acute trouble developing in a recognized case of chronic salpingitis, the possibility of further complication must be thought of from the normal proximity of the appendix. This liability is also owing to the pathological fact that in these chronic cases follicular changes in the appendix are generally found of greater or less severity, being due to infection by contact, adhesion, or through the lymphatics. Hence, with a case of old tubal disorder developing sudden pain, not at the menstrual period with gastro-intestinal symptoms, with the tenderness developed by vaginal touch extending above the range of the tumor, a conjoined disease may be suspected.

Hydrosalpinx should never be mistaken for appendicitis. There are more of the aggravated subjective symptoms; merely infrequent spasmodic pains with pelvic pressure, and locally the fluctuating tumor usually in the pouch back of the cervix.

The same may be said of *hæmato-salpinx*. In the pain from its sudden formation, although colicky we shall fail to find the symptoms of local peritonitis and the gastro-intestinal symptoms will be lacking. In cases of rupture of either of these sacs the symptoms of general peritonitis will usually show themselves.

Tubal Pregnancy should be easily diagnosed by the clinical history. Usually sterility for some time followed by temporary cessation of menses, then irregular flow for some weeks, discharges of decidual membrane and mammary changes. Then come paroxysmal pain, followed by sudden cutting pains with evidences of collapse—subnormal temperature, rapid pulse, cold sweat. There is no abdominal rigidity although there may be tenderness. There may be dullness low down in the abdomen, which could not be present at that stage of appendicitis. By vagina the vault will be boggy and full with the uterus usually crowded down or to the side. Perforation of the appendix before adhesions have formed is the only condition of that organ which could possibly simulate tubal pregnancy. In the former however, we usually have a chill, diffused pains and seldom any signs of tumor locally or in the vagina. The collapse is one of shock rather than of anæmia and is rapidly followed by symptoms of general peritonitis.

Inflammation of the ovary (oöphoritis) is generally associated with and dependent upon disease of the tube, but it may be menstrual as the result of exposure during that period,

The condition of tubo-ovarian congestion is a mild form of this trouble, most evident at the time of the flow. There is slight fever, nausea, and vomiting with some abdominal tenderness. The symptoms usually disappear by the second day when the nature of their origin is apparent.

Oöphoritis in its severe form has more serious developments. It comes on after the period with a chill, fever, nausea and vomiting with great soreness. The vaginal tenderness is acute and the gastric symptoms are increased by any manipulation. Unless in a mass of exudate the outlines of the ovary can be made out and the seat of the pain learned. It is often prolapsed.

Abscess of the ovary may be the result of such an inflammation but usually originates from a purulent tube—not necessarily a pyosalpinx—and is bound up with it in adhesions. Its fever is septic with chills and a varying temperature. The condition must be found out bi-manually. The tumor is generally well outlined round or oval, fluctuating, pressing well down into the cul-de-sac, with the uterus displaced.

In only two conditions should ovarian cysts be mistaken for appendicitis.

In a suppurating dermoid cyst there is local tenderness low down in the iliac fossa with a hectic fever. The pain is dull and constant, seldom colicky. Unless sepsis is well marked there are no gastrointestinal symptoms. By the vagina the tumor is well outlined and its location and origin defined.

In the case of a small tumor with a twisted and strangulated pedicle, the attack is sudden the pain and tenderness severe with symptoms of shock. The discovery of the tumor should clear the diagnosis.

I am obliged to omit many conditions of rare complications and have only tried to bring out what seem to me to be salient points in the diagnosis of conflicting diseases. But it must be noted that many symptoms are held in common and that the description of the subjective symptoms of most forms of pelvic inflammation is hardly more than a reiteration. There is no pathognomonic sign to distinguish between them and what might be called pelvic appendicitis.

Furthermore, in the interest of the patient it is necessary to admit that all cases are not capable of being diagnosed previous to operation. There may be acute inflammation of both tube and appendix, acute of either with chronic of the other, chronic of both, acute appendicitis with ruptured or unruptured tubal pregnancy, with confusing symptoms, whose severity does not warrant an ante-operative diagnosis. In all such cases of grave doubt the post-operative diagnosis of the surgeon is usually more satisfactory to the patient than the post-mortem diagnosis of the pathologist.

DISCUSSION.

Dr. Alonzo Boothby: Mr. Chairman, Ladies and Gentlemen: I know just about as much about the paper as you do, as I have simply listened to it, and if I made any preparation it would be on the general subject and not on any particular point that the doctor has made or failed to make. There are two or three things, however, that I shall be pleased to say to you. The first point I would make is that, while the appendix is quite uniformly found coming off from a particular point of the colon, yet we cannot say the position is entirely definite, because the position of the bowel is not definite. In one patient I had recently I could remove the appendix out from the vagina after the vaginal hysterectomy without any trouble. Now if the appendix was in the place usually designated for it, that could not be done. This point, it seems to me, has a great bearing in differentiating between the two diseases. Now, why is it necessary to diagnose between these two troubles? I should say that it is simply this, because appendicitis is the more dangerous disease, owing to its situation and from the causes which produce it, and it is more likely to progress, not being so apt to be protected by a limiting membrane which prevents a rupture into the peritoneal cavity. Now, I cannot see but what this covers the importance of the diagnosis between the two.

In relation to the position of the appendix, I wish to refer to the case of a boy where the appendix projected down into the pelvic cavity. It was about $1\frac{1}{2}$ inch in diameter—a most unusual thing. Symptoms in this case were not different as I know of. With the same symptoms the course would be about the same for relieving it. That is, if it came to a surgical operation in a woman, the pus cavity might be emptied from the vagina, although in a pus case I believe we should not want to undertake it. Now I have found that the character of the inflammation assists in diagnosis, because when coming from the uterus the pus coming from the tube is not so virulent as that coming from the bowel. In the case of appendicitis you have very frequently the streptococci. Then you have quite frequently the staphylococcus, the bacillus coli and other forms, while from the tube you have the gonococci, which does not produce so violent inflammation.

Now, Dr. Perkins spoke of the rigidity of the muscles in appendicitis. That is a very important symptom in appendicitis, but it may also exist in the tubal inflammation provided there has been a peritonitis, and rigidity as I understand it, is due to a previous peritonitis. Now, in a sudden attack of appendicitis as it comes up, in the more slower inflammation of the tubal character you do not have the rigidity as marked as in the regular tubal inflammation. If there be a

general peritonitis with the appendicitis, then you have rigidity in proportion to the peritonitis on the other side. Now, there is a great deal I had thought of saying on the subject that does not now occur to me, but Dr. Perkins has covered the subject very thoroughly, and the paper is well worth your consideration.

Dr. Hodgdon: I am very glad indeed to have listened to as good a paper as this upon such an important subject. It is certainly very interesting to me to note the subjects of both. It is no easy matter to make a diagnosis of ovaritis which has gone on to pus formation. There are many symptoms in common. We have all made diagnoses which are satisfactory to the patient and to the friends but not to ourselves. We are often doubtful. Two cases occur to me which I was called to see early in my practice. Case No. 1 was a lady 20 years of age who had been sick about two weeks. I was called in consultation and found this history. Extreme pain in the right inguinal region with a good deal of a temperature, with all the symptoms from typhoid fever up to tubal and ovarian troubles. This case occurred before I had ever heard of appendicitis, about eleven years ago, and the diagnosis could not be made along that line, but there was a diagnosis made of an inguinal abscess. It was opened and the lady went on to a fair recovery. There was some relief. Four or five years later I saw this same case again, and she had the same trouble. I sent her to the hospital for an operation. The appendix was removed, and the ovary and tube were in perfect condition, since which time she has been in perfect health. In this case it was an ignorant diagnosis.

Case No. 2 was a young girl fifteen years of age, and gave somewhat the same history as the above case. I supposed that there was some trouble with the appendix and made the diagnosis accordingly. An operation was resorted to and a pyosalpinx found, tube and ovary removed, and a few days later a septic condition set up and patient died. This was to my mind an almost perfect tubal case. An ignorant diagnosis in the first case, a mistaken diagnosis in the other. There are many symptoms in common. The most common symptom to both is the localized peritonitis. Where it has gone on to pus we get a localized inflammation in the right inguinal region and circumscribed. We get nausea and vomiting in both, tumor in both, and constipated bowels in both. Extreme tenderness to pressure and touch in both. There are, however, two or three symptoms which I have observed, and which aid me in diagnosis. In appendicitis the pain is more severe and is apt to be localized, while pain from the ovary runs about more and possibly down into the thigh. Also another point which has just been referred to by the previous speaker, rigidity of muscles. I think it is stated on pretty good authority that if there is extreme rigidity of muscles in the right inguinal region

there is inflammation of the appendix. If it is extended generally over the abdomen it is more apt to come from the ovary and its appendages. This is all I can say after the excellent paper and its being so thoroughly discussed by the previous speaker.

Dr. W. L. Hartman, Syracuse, N. Y.: This is such an excellent paper that it would be impossible to hurt the author's feelings in any discussion. He has said everything that could possibly be said about the matter. I would like to say, however, that in examining per rectum, there is a decided difference in the feeling on the right side where there is a pyosalpinx. There is a more rigid feeling. When you get an appendicitis and if the abscess extends downward you get a softer feeling. I had a case about three years ago, of a boy five or six years old. The abscess extended down three or four inches, and by passing my finger into the rectum I could feel the abscess. Now, if I may be permitted to go from this subject, I have noticed in two or three cases where there has been rupture of the appendix, the intense pain in the male following down to the end of the penis after the rupture. After this pain was over the patient was perfectly comfortable for about three hours time. That is an important point I think about distinguishing between appendicitis and renal colic. Further than this I have nothing to say, as it was such an excellent paper, and has been so ably discussed.

DOUBLE HARE-LIP AND CLEFT PALATE.

BY CARL CRISAND, M. D., WORCESTER, MASS.

It has always seemed to me that any deformities which mar the symmetry of the face must cause more embarrassment to the individual than those of other parts of the body, because they cannot be covered up by clothing or other means. They excite our deepest sympathy and the surgeon whose skill and mechanical ingenuity are capable of transforming a repulsively deformed face and deficient mouth into one which will be "a thing of beauty, and a joy forever" is truly a great benefactor to the unfortunate individual and even to the whole community at large.

Hare-lip is certainly a deplorable facial blemish, but a continuance of the cleft through the hard and soft palate is still worse. The former can easily be remedied, but not so the latter. Great ingenuity has been displayed in devising obturators to cover up this defect and many have been the disappointments to surgeons who have attempted to close the cleft.

The study of this subject has become particularly interesting to me through the case which I am about to present. And right here let me say that I regret very much to be obliged to bring this case before the society in an unfinished condition ; I had hoped to have it completed ere this. You will acknowledge that quite a transformation has been wrought, but a great deal more can and will be done. The boy's parents are so much pleased with the improvement in his appearance and speech that they are reluctant about having anything more done at present ; but in justice to myself and the boy (for he will not realize the gravity of his condition until later in life) I shall insist upon "finishing the job" some time.

In the incipient embryo the upper lip is represented by three germinal buds, which finally coalesce and form the lip, and the origin of hare-lip has been referred to an arrest of development of these primary components of the lip. In the new-born infant traces of the union of the three sections of the upper lip are sometimes discernible.

In the embryonic development of the upper jaw the lateral maxillary processes approach each other, the intermediate naso-frontal plate grows downward and is named, from its position, the incisive plate. Continuing in their growth the incisive plate and the lateral maxillary processes unite and close the regular gap, thus forming the upper jaw. The fusion is so complete that in the normal adult all traces of the primitive fissure have vanished. As already stated these clefts between the lateral and middle maxillary segments are normal in the embryo up to a certain stage of development, but progress may be arrested in the lip, causing hare-lip; in the bony structure, cleft palate, and when lip and bone are involved, we have a labio-palatal cleft. The case before us shows evidence of arrested development in both soft and hard structures on both sides; quite a rare condition and therefore all the more interesting to us.

The principal causes of this trouble probably are : disturbances of nutrition ; defective blood-supply and maternal impressions. The latter is discredited by Lane, except previous to the third month when the foetus is still adherent to the uterine wall and consequently in touch with the uterine nerves. After this period, the foetus is separated from the mother by a nerveless funis and therefore communication through the medium of nerve-roots is impossible.

Among the rare forms of the hare-lip are found : cleft of the upper lip extending upward to the lower eyelid ; median cleft of the upper or lower lip ; one case of the latter variety was observed by Parise, of Lille, in which even the tongue was bifid and the lower jaw was cleft anteriorly. This condition is oftentimes co-existent with deformities of other parts of the body.

The question, when is the best time for correcting this deformity, is a most important and perplexing one. It is a question upon which there is a great diversity of opinion. Some surgeons favor operating

at birth, or very soon after, and for the following very commendable reasons, viz. : the muscles of the face and mouth are still weak, their contractile power is only slight and consequently, there is less danger of the united parts being torn assunder ; the tissues are more vascular and therefore their plasticity greater.

Undoubtedly the best time in all cases would be before the child learns to talk.

The restoration of the lip and palate serves a double purpose, viz., in infancy to aid alimentation ; later in life to obtain normal speech, and for its cosmetic effect. A boy, of course, has the prospect of covering the defect with a moustache, but the hirsutic covering, kind as it appears to be, cannot help the boy's speech, which is far greater a blemish than the ugly appearance of the cleft itself.

For a description of the operation I will, with your permission, quote largely from a most excellent paper by Truman W. Brophy, M. D., D. D. S., of Chicago, entitled : "The Radical Cure of Congenital Cleft Palate", which he read before the National Dental Association last August ; vide, *The Dental Cosmos*, September, 1899. Having operated upon several hundred cases, there is probably not another operator in the country who understands the work as well as he. He is a most ardent advocate of operating in early infancy, ten days and upward. He argues that surgical shock is much less ; mental apprehension (a large causal factor in shock) is eliminated ; the bones are more easily cut and shaped before calcification ; the muscles are more easily united before they become strongly developed ; the operation brings the muscles into proper action and they therefore develop instead of atrophy. Without the operation, as time goes along, they become useless and cannot easily be made to perform their proper functions. Early union by surgical means favors their development "pari Passu" with their fellow muscles of the mouth. Even the bony structures, although contracted by the operation for cleft palate, gradually broaden out and the teeth meet those of the lower jaw in proper apposition. Less deformity follows the early operation. A most important argument in favor of the early operation is that of speech. If done before the child learns to articulate it has no faulty habits to overcome.

Dr. Brophy believes in the heredity of this condition, and in support of this belief mentions one family of six children, four of whom he has operated upon. The paternal grandfather was similarly afflicted.

Operation. Remove the edges of the fissure, also through the edges of the bone ; hold up the cheek just back of the malar process, and high enough to escape all danger of not being above the palatal plate of the bone, insert a large braided silk suture, carrying it through the substance of the bone so that it will come out at a corresponding position upon the opposite side. The silk suture is more easily intro-

duced, but a silver wire suture should be substituted for it and drawn through in its place. The wire should be about No. 19 and may be doubled in case the condition of the parts and the tension upon the tissue necessary to approximate them seem to require it. Nearer the front position of the palate insert another wire, carrying it through the substance of the bone above the palatal plate and out through the other side in a position corresponding to the place of entrance. Thus we shall have a wire passing over the plate in front of the malar process and another one behind it. These wires are passed through a lead plate on each side over which they are drawn together and twisted until sufficient tension is created to draw the edges of the cleft together. If this cannot be accomplished "from lack of tissue or from firm resistance of the parts the strain is too great, there is a further step to be taken, which will obviate those difficulties. After the cheek is well raised, divide the mucous membrane and bone through the malar process. Carry the knife in a horizontal direction and when well inserted, sweep the handle forward and backward. In this way a maximum amount of bone and a minimum amount of mucous membrane is divided. This done on each side, the bone can very readily be moved toward the median line. The wire sutures, passing through the lead buttons, may now again be twisted and the cleft of the hard palate be closed by approximation of the two sides. The incision in the mucous membrane, in making the separation of the bones, is made as small as possible, as this membrane must serve to retain the bones in proximity or to hold them near together." A few silk sutures are introduced to coapt the mucous membrane. "The lead plates are to be left in place from four to eight weeks, but the silk coaptation sutures should be removed about one week after the operation."

It has been my good fortune to see Dr. Fillebrown of Boston, operate and to see some excellent results of his work. Instead of sacrificing any mucous tissue along the borders of the cleft in the palate as Brophy does, he cuts along the edge of the cleft down to the bone; dissects the periosteum away from the bone out to the teeth; introduces silver wire across the palate supported on either side by small silver plates about $\frac{1}{4}$ by $\frac{1}{2}$ inch in size; this draws the flaps into good apposition where they are held by means of silk interrupted sutures. To relieve the severe tension on the wires, he cuts longitudinal slits through the entire mucous membrane and periosteum parallel with the line of the teeth.

The old method of perforating the hard palate and cutting the bones on either side parallel with the cleft has been discarded; the above described operations are much less dangerous, and difficult and accomplish the desired object very satisfactorily in the majority of cases.

DISCUSSION.

George B. Rice, M. D.: I fear an unfortunate selection was made by Dr. Packard in courteously asking me to discuss this most interesting and instructive case of Dr. Crisand's. I have never operated upon a case of double hare-lip and must therefore speak from theoretical rather than practical knowledge of the subject.

Josh Billings once said, "It is better not to know so much than to know so many things which ain't so." In my opinion theorists are apt to know a good many things which "ain't so." I must therefore ask the members of this Society to accept my remarks with mental reservations more than ordinary.

The great difficulty in operating upon many of these cases seems to be that of disposing of the prominence of the intermaxillary bone; and I believe Dr. Crisand has not mentioned the devices for overcoming this obstacle. It may be oftentimes comparatively easy to adjust the flaps of the soft parts to close the fissure; but when the intermaxillary bone or incisive plate as it is sometimes called is ununited to the lateral plates and is forced forward by the growth of the vomer, then some means of disposing of it must be adopted. The segment is occupied by the two incisor teeth—the whole thickness of the alveolars, the corresponding part of the floor of the nose and the anterior nasal spine.

Its posterior surface articulates with the anterior end of the vomer. Authorities differ greatly as to the best method of disposing of this small segment of bone.

It is not considered good surgery to remove it because of cosmetic and functional reasons; therefore some process of resection or other means of reduction of the vomer must be undertaken.

Here perhaps the experience of one familiar with nasal surgery may be of some value. Of all the methods suggested for reducing the vomer the modified Blandin operation used by Rose seems the most simple and the operation least likely to cause an injury to the nasal septum, which would afterward impair the function of the nose. It consists in separating the muco-periosteal coverings, making a vertical cut through the whole thickness of the vomer, separating attachments below if necessary, and then sliding the anterior fragment backward causing it to overlap the posterior portion to an extent sufficient to give the needed space. The intermaxillary bone can then be easily pushed backward and a good foundation given for the adjusting of the soft tissues over it. If after union has taken place and inflammatory symptoms have subsided and the over riding of the fragments of the vomer cause interference with nasal respiration, the removal with nasal saw of the redundant tissue is a procedure easily accomplished. It must be admitted that the primary operation on the vomer would not be unattended with difficulty unless one were provided with a good reflected light and the delicate instruments devised particularly for septal operations.

FLOATING KIDNEY.**Report of a case, with operation.**

BY G. FORREST MARTIN, M. D., LOWELL, MASS.

Floating, movable, or palpable kidney, as it is variously termed, is not a subject which presents itself for daily consideration to physicians.

Still, its correct diagnosis and management when it does occur, are of importance, and well worth our consideration. This fact and the desire to report and record an interesting case, shall be my excuse for this paper.

That there should be a marked difference of opinion among physicians as to the frequency of this trouble, is to be expected. But it is perfectly safe to assume, I think, that it is more common than is usually supposed.

I find one authority claiming that one woman in every six has a movable kidney. Another says: "There is a tendency to diagnose this condition too often in obscure kidney disease. Like the diagnosis of epidemic influenza, it is made to cover a multitude of varied conditions." It seems to be the most common between the ages of twenty-five and forty-five years, though one writer records ten cases at ten years, and four at seven years. About 85% of all cases are in females. About the same proportion are on the right side. The pressure of the liver and the greater length of the renal vessels on that side are given as reasons for the latter; tight lacing and frequent pregnancy for the former.

Movable kidney is almost always an acquired affection. Wasting of the peri-renal fat in exhausting diseases, may be a factor. Trauma, and the lifting of heavy weights occasionally bring it about. Then there is that condition which has been described by Glénard as *Enteroptosis*, a special group of symptoms characterized by nervous dyspepsia, prolapse of the abdominal organs, especially the transverse colon, with looseness of mesenteric and peritoneal attachments, so that there is a falling of the organs which they should suspend.

In examining for this condition, bi-manual palpation, the patient lying in a relaxed position, is the most satisfactory. Directing the patient to take a deep, full breath, thus forcing down the diaphragm, may assist in bringing the organ within reach. The sensation on touch is described as a sickening one more than an actual pain.

In regard to the symptoms, many cases give no trouble whatever, and may be left unmolested. In others there is pain in the lumbar region, with a sense of dragging and discomfort. There may be an intercostal neuralgia. In a large group, the symptoms are those of

neurasthenia with dyspeptic disturbance. In women hysterical symptoms may be marked, and in men various grades of hypochondriasis. Hence we are cautioned not to be too ready to inform a patient of our discovery, should we accidentally find this trouble present in making an examination. A depressed and dilated stomach is a frequent accompaniment. Many subjects are liable to attacks of sharp, colicky pain in the abdomen, often with chills, nausea, vomiting, fever and collapse. There may be severe pain in the testicle or labia. Such attacks may be confused with renal colic, intestinal disease, or recurrent attacks of appendicitis.

It was in 1864 that Dietl described these attacks, and the name of Dietl's crises has since been applied to them. He considered them due to twists or kinks in the renal vessels, or strangulation of the kidney owing to extreme mobility. When we remember that the ureters are sixteen or eighteen inches long, this theory certainly seems reasonable. During the attacks the urine is sometimes high colored, and contains an excess of uric acid or oxalates. Blood or pus may be present. Intermittent hydronephrosis has sometimes been associated with movable kidney. The kidney may be tender, swollen, and less freely movable than usual. It seems clear that many of the most severe symptoms are produced by the reflex irritation, rather than the mechanical action, and that this form of irritation may be so severe as to inhibit secretory and even motor functions of the parts affected. In all cases of severe obscure abdominal pains, a systematic search for a movable kidney ought to be made.

Treatment. As the condition is not one which immediately threatens life, the treatment which is the most rational, aims to restore the natural pad of fat, and to keep the organ up in place mechanically. At the same time remedies aimed to reduce the reflex irritability of the visceral nerves should be given. Codeia is said to be especially valuable here. The general nervous system must receive attention, and careful diet be selected. The excess of uric acid or the oxalates must be met by the diet and remedies. When the attacks of acute pain are due to the aforementioned twists or kinks of the pedicle, change of position or careful manipulation may give prompt relief. Sometimes complete relief is afforded by a broad, well-fitted, elastic abdominal band, perhaps with a pad (preferably an air pad) to the right of the umbilicus.

But when the kidney, besides being movable, is the frequent seat of the crises of pain, the general health is suffering, the patient becoming incapacitated for work, something more is generally required. And here comes in the operation of Nephrorraphy, first performed by Dr. Hahn of Berlin, I believe in 1874, and which has since met with favor at the hands of many surgeons. While there is still a strong opposition to operative procedures upon the kidneys, because of the high death rate, the objections do not hold with equal force in

this operation. In one hundred kidney operations recently reported by Fenwick, an English surgeon, he lost nine. But, of the one hundred cases, eleven were nephrorrhaphies, and all recovered. It certainly belongs in the category of conservative surgery.

The operation consists in cutting down in the kidney region, through the muscles and fascia, and fixing the kidney by a few stitches, or by granulations. Some writers claim successes by the simple incision and opening of the fat capsule, the resulting inflammation causing adhesion, and the wound healing by granulation. To me the stitches seem more reliable, and a cleaner, more satisfactory surgical procedure. Silk, sheep-gut, plain and chromicized, silk worm gut and kangaroo tendon have all been tried. The two latter seem preferable to the writer, if a reliable article is at hand. After several experiences with troublesome little abscesses, months after "perfect results," in cases where silk stitches were left buried in the tissues, I have strong aversion to leaving silk in such an organ as the kidney. On the other side of the question, however, it is but fair to quote a passage from Dr. Robert Morris's Hunterian lectures of last year. Dr. Morris now always uses silk. He says: "I see from time to time, patients upon whom I operated nine or ten years ago, with their kidneys as firmly fixed as can be desired, and who have been quite free from their former symptoms ever since the operation. Moreover, I have had the opportunity of witnessing in the living bodies of some three or four of my patients the sound and complete holdfast which this method affords. It has a few times happened to me from six to twelve months or longer, after fixing a hydronephrotic as well as after fixing the healthy kidney, to have to do a second operation for quite different reasons, upon the same organ, and I have then seen my sutures imbedded in a mass of tough fibrous tissue, and have had to pull or cut them out from the renal parenchyma, before I could detach the kidney. Here they had for months harmlessly remained without showing the least tendency to become the nuclei of calculi, as some surgeons anticipated would be the case." I have thus quoted at length from one of the best of surgeons, not alone for the bearing of his remarks upon the question of ligature which we were discussing, but for the pointed application it contains to the whole topic of renal surgery.

Let no man suppose when he undertakes this operation for the first time, that it is an easy one to perform. When you have cut through the skin, fascia, ext. and int. obl. muscles, the transversalis, and the lumbar fascia, you are working as it were, with the ends of your fingers, and in the bottom of a deep well of tissue, and the close approximation of the twelfth rib above and the crest of the ilium below, make firm walls to prevent much expansion. The kidney is brought into the wound by the pressure of an assisting hand in front, the fat is opened, and the renal capsule incised and peeled back to expose a

raw kidney surface for adhesion, and two or more stitches are made to pass through the capsule and the kidney substance to the depth of one-fourth to one-half an inch, and then out through the muscular wall. Some have simply sutured the fatty, and others the fibrous capsule alone to the muscles. Still others have attached the kidney to the periosteum of the twelfth rib.

Case. Let me now briefly sketch my own case. It was that of T——G——, a mill operative, age 24, habits good, Armenian by birth. He has been sick for sixteen months, with indigestion, vomiting, constipation, and severe abdominal pains. Eleven months ago he went to the Mass. General Hospital for treatment. After being there for a time, during which his attacks of pain in the right side were severe, he was transferred to the Tewksbury Almshouse. While there, a diagnosis of floating kidney was made, and some support was, I think, provided. He did not improve, and came into the dispensary clinic of my associate, Dr. Van Deursen, who referred him to me. At this time he was considerably emaciated, and an examination of the urine showed a deposit of albumen amounting to 2%. I disliked to operate under these circumstances, and put the patient under observation and treatment for about six weeks. The albumen did not diminish, and sometimes amounted to 3%. I then sent him to the Lowell General Hospital, and put him to bed for a week. There being no improvement I decided to take the chances that the albumen all came from the loose kidney, and to operate. The fact that the specific gravity remained high all the time encouraged this belief.

Operation July 3d, '99. The oblique lumbar incision was used, parallel to and about one inch below the last rib. The abdominal cavity was readily entered, and the peri-renal fat found to be little more than a few oil globules. The kidney was pushed up into the wound and found to be normal in size and appearance. The capsule was incised and an attempt made to place the stitches. Here the trouble began! I have never yet experienced so much difficulty in putting two stitches in place. It almost seemed as if that kidney was endowed with reason, and knew just when to slip away to avoid the prick of the needle. By the use of tenaculum forceps, however, it was finally held in place while two stitches of chromicized sheep gut, No. 3 were inserted about one-fourth inch deep, and three-fourths of an inch in width into the substance of the kidney, through the capsule, and the deeper layers of the muscles, where they were tied and left buried. The wound was closed and healed by first intention. About two weeks after the operation some soreness developed about the wound, and gentle pressure brought out a drop of pus. I opened carefully, passed a probe, and found one of my stitches. This was removed. In three days the same thing was repeated in the second stitch. This too, was removed, and the small sinus soon closed up. The kidney remained firmly in place. The patient was kept on his back

for one month, although he was carried out of doors on a frame on pleasant days.

The diet was carefully selected, and the bowels kept free. To my surprise and relief he passed 34 oz. of urine the first day, albumen about as usual. From this time on, however, it steadily diminished, and on the eleventh day was entirely gone, and did not return. I had an opportunity to examine the urine last week, and found it an absolutely normal sample. Patient was discharged Aug. 28th, about 20 lbs. more of a man than when he entered the hospital, and he is now at work and doing well. There is a considerable enlargement of the liver in his case for which I am now giving him treatment. This may have been the chief cause of his displaced kidney, although there was also a history of severe straining and lifting to account for it.

The two points of most interest to me in this case are, first, the pronounced and permanent relief from the albuminuria following the operation, and secondly, the experience with the chromicized gut. I have heard the claim made by good surgeons that the hardening of the outer layers of the gut produced by the chromic acid, prevented the central portions from being thoroughly sterilized. The fact that, in my case, two weeks elapsed before any signs of trouble appeared, would seem to explain the trouble in that way. During my entire service of two months at the hospital, this was the only drop of pus that we had following an operation.

DISCUSSION.

Dr. J. Emmons Briggs: I would like to compliment Dr. Martin on his paper, and especially on the excellent results obtained in his case. I have had pus occur in cases myself two or three times. In addition to the symptom of fluctuating kidney which he has mentioned, I would like to say it has been my experience to meet with one particular symptom which the doctor has mentioned. Especially that sickening sense on palpation, rather than any marked tenderness. In one case it was exceedingly marked. Very little pain only that sickening feeling almost amounting to nausea. The Doctor also spoke of the narrowness of the field of operation, there being so little space between the lower rib and the crest of ilium. He probably used the same method which others have. Still, I have met with the same trouble myself, but happily that space can be increased very greatly by the position of the patient. For instance, if you wish to operate on the right kidney, the patient being on the left side on a pillow, then there is opened up quite an area between the lower rib and the crest of the ilium. There can then be made quite a long incision. Of course care should be taken, for the danger of thus making an incision is that the lower portion of the incision may open into the peritoneal cavity.

The doctor also mentioned that the kidney receded from the needle, and made it difficult to insert the suture. It seems to me that trouble can be obviated by a suture transfixing it, or by using the tenaculum. There is sometimes difficulty in getting hold of the kidney. That can be accomplished by the assistant pushing the kidney up to the line of incision, then transfixing it with the forceps.

Now, there are several different methods which Dr. Martin has spoken of for suturing the kidney in place. I have used in a limited number of cases the following method of splitting the capsule of supra renal fat. That is best removed because it gives an opportunity to bring the kidney up to the peritoneal wall. Then after the kidney is brought into place an incision is made along the dorsum of the kidney through the capsule, which is lifted back a little, leaving the surface of the parenchyma of the kidney well exposed. Then I suture the kidney to the wall all the way round. Then I introduce two silk worm gut sutures, bringing them out through the skin. This serves to hold the kidney in place, and at the same time to close the wound.

Now, just a word or two in regard to silk sutures. The doctor had some trouble with a small amount of suppuration. After a lapse of quite a long time, when the union had apparently been complete by first intention, he noticed a little soreness and a few drops of pus, the suture coming away. That has been the experience I think of quite a number of surgeons who have used silk. It should not cause suppuration. Still, it might if carried into the parenchyma of the kidney. I have seen it happen once or twice, the pus coming out along the line of the silk worm suture. When it healed by first intention there was a tendency for pus to come out along the line of suture.

The cause of Floating Kidney of course none of us can determine, but Dr. Martin thought that an enlargement of the liver may have had something to do with his case.

Dr. Krauss: It is no easy matter to consider such a complete paper as that of Dr. Martin's for discussion, but I think I may take exception to one point, and that is the manner of examination for floating kidney. I do not think it is sufficient to examine the patient simply in a lying position. I usually examine these cases in three different positions. First, in a standing position because the movable kidney will move downward; second, in a lying position because the kidney will move backward; finally, face down, because it will move forward. There is one other point which is perhaps a little inexact. The first operation for fixation of the kidney he states was in 1874. I think it was 1808. But, Mr. Chairman, I want to say that I am delighted with Dr. Martin's paper. It shows great ability and brings to our notice a most interesting pathological condition. I wish to remind Dr. Martin that the condition of movable kidney is not a rare condition. Owing to the fact that many people are very thin, and the fat which holds the kidney in place thus being

reduced, and especially where the liver is enlarged, we cannot wonder that the kidney is frequently displaced. Often the movable kidney is mistaken for something else, trouble with the liver, gall-bladder, anything else but the movable kidney being thought of, because the graver conditions always come first to our mind. The kidney may go to the middle line of the abdomen and even to the symphysis. It is no wonder that many of these cases are treated for months and even years for dyspepsia before movable kidney is even thought of. The lesson that we are to learn here, it seems to me, is that the displaced kidney must be replaced, and carefully replaced, and it will do much to bring these patients back to health with the aid of a nourishing diet.

Dr. Hartman: I think that the reason so many have ill success with this trouble, is that they do not suture their kidney thoroughly enough. They do not get it firm. I always split the capsule open and scarify it, making it as raw as possible. I use silk worm gut for suturing, and I leave my silk worm gut in for three weeks. I always close up wound entirely. I use silk worm gut for two reasons. I do not like silk, and do not like cat-gut down there, as it absorbs too quickly and it is liable to carry infection from the outside. I remove the silk worm gut and the substance of the kidney is in its normal condition. Now what do we get with silk? For at least a half inch around the silk suture you will have an atrophy of the kidney substance, which will never return to its normal condition on account of the silk; that is, if your silk does not suppurate out. After operating for movable kidney I keep my patients in bed for four or five days usually, and before I allow them to get up I put a pad or truss on and tell them to keep it on three months, and that will keep it in place until the repair is so complete that it cannot get away.

Dr. Packard: The case of which Dr. Briggs spoke is worthy of passing notice. There was a bunch in the right side. I made an examination and determined to my satisfaction that there was a bunch there. There had been an opening made, and they said it was floating kidney. I thought if this prominent surgeon had had his hands on it, it certainly must be floating kidney. The scar was straight up and down the side. The space was very short to work in, to suture any dislocated kidney in place. However, I told her that I would try to relieve her. I made an oblique incision, parallel with the lower rib, which gives a longer opening. On coming down to further end of it there was a good firm adhesion where he had sutured the kidney. On carrying the finger further forward I found that it was a gall bladder full of gall-stones. I made an opening and took out 116 gall-stones. There was no movable kidney in that case.

Dr. Martin: To close the subject, in the first place with reference to working with a pad under the patient, I tried it but was obliged to abandon it on account of the pressure. In regard to the line of in-

cision, I said that I used the oblique incision parallel with the lower rib. In regard to examining for the trouble. I said that I examined patient in a relaxed position; I did not say that it was standing or any other way. I am aware that there are a great many points not touched upon, but the subject is so great that I was obliged to be brief, and not dwell upon them as fully as I would like.

THE IMPORTANCE OF CORRECTLY DIAGNOSING INJURIES TO THE HEAD.

BY W. LOUIS HARTMAN, M. D., SYRACUSE, N. Y.

Injuries to the cranium are very frequently met by the general practitioner and oft-times are very hard to determine their extent from their external appearance, as at times there will be no contusions which are noticeable upon the scalp and the skull may be found very extensively fractured. Of course we must look very closely at the different symptoms of concussion and compression of brain and determine, if possible, if we have concussion or compression. This is at times a very hard thing to do as the symptoms are closely allied and one may be deceived in his case, not-with-standing the fact that he may be the most astute observer, so the only thing to do when in doubt is to make an exploratory incision through the scalp, and then determine the exact nature of the injury and govern your treatment accordingly.

We usually find coma with extensive fracture and depression which is noticeable from the exterior, and the patient in a few hours will regain consciousness. We may find the same condition in a simple case of concussion. We may even have the injury to the extent of laceration of dura mater as in a case I will cite later.

It is always wise to determine without a doubt the exact nature of an injury to the cranium when there is the least symptom of fracture, as we may have a fracture and at the time have what may seem to be a complete recovery and in six months or possibly two years there will develop some nervous trouble, such as Jacksonian epilepsy, as the result of a cicatrix caused by the original injury, which at this time will not be so conveniently and successfully managed.

We cannot always tell just how and what part of the nervous system will suffer. Suppose we have an injury over the sight centers and before we decide just what the trouble is we have an atrophy of the optic nerve, an irreparable condition, and our patient has darkness before him the balance of his days. Could we ever forgive ourselves, knowing our negligence had been the cause of a patient's total blindness, had drawn a black shade over a patient's eyes, one that never could be raised by human hands? Those are unpardonable errors, as

by careful inspection something might be discovered to prevent such a calamity.

With your permission I will cite a case wherein this occurred. Mr. L. P., age 52, while coming out from the North Woods in September 1896, riding on a buck-board, an old limb fell from the top of a tree striking him on the head in line with the top of the ear two inches posteriorly, the scalp being somewhat lacerated but not sufficiently to expose the bone. He was dazed for a few moments but rallied and drove for some ten miles to a railroad station, took train and rode twenty-five miles where he was attended by a physician, who cleaned the wound thoroughly on which he applied compresses of arnica, changing them frequently during the night. Next morning patient was considered all right. He went on about his business thinking he was in as good condition as ever, until the last of October. Being employed by a woollen manufacturer, one of his duties was to select qualities and colors of cloth which in his judgment would be most salable. He discovered that his sight was not quite as good, that his field of vision was smaller than usual. He did not mind this for several weeks as it was slight at first, but as time went on, his failing eye sight progressed and he consulted his family physician who declared that there must be some syphilitic history. This the gentleman protested against as he said there was no such history in the family, neither was he affected in this way.

From his family physician he went to a noted eye specialist in New York who declared that it must be of syphilitic origin. The gentleman again protested but it was of no avail as they put him on the iodine and mercury treatment and continued this for several months. As he grew steadily worse under this treatment, he was examined for locomotor ataxia but all symptoms, with the exception of unsteady gait were lacking, and they decided that this was not the trouble. He visited several men after this without benefit. Strange to say none of these gentlemen inquired into the history of a possible injury to the head; however, they were told of this injury but did not place enough significance upon this part of the history to even make an examination, deciding it was an atrophy of the optic nerve due to either specific origin or diphtheria which he had had some sixteen years previous.

I examined this patient in March 1898, and found upon close examination a slight depression of the outer table of the skull, situated over the cuneus. My diagnosis was atrophy of the optic nerve as the result of pressure upon the cuneus due to an undiscovered fracture at the time of injury in 1896.

Now you will say why did you not operate? Simply because there was a complete atrophy of both optic nerves, therefore it would have been useless to have operated for that trouble, and then the time was so remote from the time of injury and there had so much change

taken place in the brain tissue, that there was a question in my mind if an operation would have been justified. However, if there had been other symptoms developing in the case, I would have advised operation as the last resort after having informed the patient of possible failure and then he would have taken the responsibility in the matter. There is no doubt in my mind had the gravity of his injuries been recognized at the time of occurrence and a button of the skull been removed which would have relieved the pressure, a complete recovery would have been the result. Now what other trouble had he staring him in the face? Jacksonian epilepsy, locomotor ataxia, paresis etc. Let me say one word right here regarding locomotor ataxia and paresis. You will of course accuse your patient of having had syphilis the first thing when you see one of those cases. Now, if their answer is negative do not at once believe them to be prevaricating, but see if you cannot elicit the fact that they have suffered an injury to the head.

Master J. A., aged 12. On May 30th, 1899, about seven o'clock in the evening was thrown from his wheel striking right side of head on the pavement. Getting up quickly he said he was not injured very much, had some pain in the right side of head which was considered of very little account. He was able to walk and was going to walk home, a distance of three blocks, when a gentleman who happened near the place of accident drove him to his home. A physician was summoned who thought there was no injury of any account. Patient visited with family during the evening until about half past nine when he said he thought he would retire, said his feet felt numb but was able to walk and complained of very little pain. At this time another physician was summoned who also said he would be all right in a short time as there was no fracture. One hour later they tried to arouse him and found him in a comatose condition. At this time they dispatched a messenger for me. I found him in the following condition; profound coma, incontinence of the urine and feces, right pupil dilated, some twitching of the muscles of the lower portion of the body, stertorous breathing, pulse 48, respiration 14.

Examination of the head revealed a slight contusion. My diagnosis being fracture, complicated with hemorrhage, I advised that he be sent to the hospital for immediate operation. At 1.03 A. M. I had patient on the table. At this time the pulse was intermittent and I feared death would occur before I could get the skull open. I made a horseshoe incision through the scalp and upon baring the skull a fracture something over three inches in length came in view. Trephining the skull revealed a large clot. I enlarged my opening in skull sufficiently to thoroughly explore and proceeded to remove the clot which to my surprise weighed over six ounces. This seems rather incredible and I may say right here that I thought that I would never get through removing clots. When the cavity was thoroughly cleaned out I found the middle meningeal artery spurting and I had some trouble in con-

trolling the hemorrhage from this but succeeded after a little. There was considerable oozing so I packed the wound with gauze. By this time the patient was quite near eternity but by the use of salines, strychnine and whiskey I succeeded in preventing him from passing over the river. He lay in a stupor for about eighteen hours when he regained consciousness and was quite himself.

Everything went on very nicely until the eighth day when about one A. M. I was summoned to the telephone and was told the patient had had a severe chill. I went to the hospital immediately and upon being told that he had a temperature of 106.4 I thought it all was up with him. Looking him over thoroughly I found his pulse was good and that he was feeling very good indeed, so I told them to prepare him for the table at nine A. M. At that time I found a slight bulging over where he had received the blow, and inserting my exploring needle to the depth of about an inch I struck a bloody serum which was purulent. I evacuated this and packed with gauze. With the exception of a few minor troubles which I had with the wound, he made an uninterrupted recovery, and at the end of five weeks the wound was completely healed and he was discharged from the hospital.

If you will bear with me a little longer I have one more case, which to me was exceedingly interesting, which I desire to cite. Mr. C. E. aged 21, was sent to me with the following history. When a lad about seven or eight years old he fell through a bridge striking on his head receiving what the physician at that time called nothing but a scalp wound. It was allowed to heal but within two or three weeks of the time of the injury he began to have a slight twitching of the leg.

This would occur once or twice a week, continuing in this way until he was about twelve years old when the spasms became more frequent. At this point it began to affect his memory. He could learn a lesson easily but would forget it very soon. From this time on the spasms began to increase, loss of memory increased and a look of imbecility began to appear until it was quite marked. When I saw him the spasms were coming on every fifteen or twenty minutes and they would last about thirty seconds. The leg would begin to twitch first, then the arm and last the mouth on the right side. It had gone to the point where he had scarcely any use of his right leg and absolutely no use of his right arm, in fact, he was unable to even close his fingers. I watched the case very closely for about forty-eight hours and at the end of that time I was thoroughly satisfied that the epilepsy was of the Jacksonian type due to traumatism, and that the brain center primarily involved was the motor center of the leg. I had him prepared for operation. After putting him on the table I made my measurements, then making a horseshoe incision I removed scalp and trephined over the leg center. Rather to my surprise I found that one side of my trephine was through the skull while the other side was quite far from

being through. I broke the button out, enlarged my opening and found upper side nearly as thick again as the lower side. I also noticed a slight depression on the skull which could not be detected until the scalp was removed, and a pronounced evidence of an old fracture where spiculae of bone had pressed on the dura mater. Directly under this I inserted my exploring needle and found a cyst which contained eight drams of fluid. There was a complete sac which I was able to remove. Hemorrhage being very profuse, I was obliged to pack the wound with gauze. When patient left the table he was suffering severe shock but recovered from this in about an hour. He had no spasms for about twenty-four hours after the operation and then he began with a slight twitching of the muscles but not all the muscles involved prior to the operation. They continued until I removed the packing but after the packing was taken out permanently he had no more spasms. About four days after this he was able to close his hand and use his arm somewhat and at the present time, two weeks after the operation, he has a good firm grip in the right hand, can use right leg as well as left, and has no more spasms or twitching of muscles. A great change has come over the expression of his face, the look of imbecility is fast passing away. This case to me is interesting from two points, first, that he complained of comparatively little pain for the great pressure which was being exerted upon the brain, second, that the use of his arm returned in such a short space of time and the rapidity with which this arm and hand has gained strength, also the marked difference in his memory now and before the operation.

The types of epilepsy which are cured by operation are those of the Jacksonian order, resulting from injury, which are not of too long standing and the cortex extensively involved. We are not doing our duty as physicians to those suffering with Jacksonian epilepsy if we do not open the skull and relieve the pressure so as to give them a chance to recover if it be possible, but in all such cases it is not necessary to do this if the case be properly treated at the time of injury. When a case of injury to the head comes to our notice, the first thing we should do is to explore the wound thoroughly and determine if an injury to the skull exists, and, if the wound be not large enough, enlarge it sufficiently to make sure that all has been discovered that may exist. I have had two cases wherein no scalp wound existed where there was extensive fracture. So when we get coma after an injury, it is always well to shave or perhaps cut the hair very close all over the head and examine very minutely for fracture of some description. Of course when you have hemorrhage from the nose or ears you will be able to arrive at some conclusion such as fracture at the base, but if fracture exist in the upper portion of the cranium you will not get those symptoms. I observed one case where the fracture extended from the right temporal to the left frontal bone, but the fracture could not be detected until the head had been shaved.

Now the operation of simply opening the skull to relieve pressure is not very formidable, in fact, I cannot see any more danger in making an exploratory opening in the skull than making one in the abdomen, which we often do if we are not satisfied with our diagnosis. If it be done with all the aseptic precautions, the patient will be able to get about in ten or twelve days. For that matter the same may be said about the operation for the relief of epilepsy, providing the cortex is in fairly good condition.

We have at times injuries involving the cranium from which there is no trouble at first. The wound may seem so small, and apparently only the scalp affected, that it would seem hardly worth more than a passing notice. Some days or possibly weeks may pass before there will be any trouble manifested, then we may get dull pain in any portion of the head perhaps involving the greater part, with violent lancinating pains in the region of the old wound. We may have vomiting, mental depression with unsteady gait, a slight tenderness in and about the old cicatrix, and possibly find what is known as "Pott's puffy tumor," slight rise in temperature, acceleration of pulse, or possibly normal pulse. There may be several symptoms present pointing to some organic trouble of the nervous system. When we find this trouble we must always be on the alert for suppurative pachy-meningitis. This condition is the result of one of two things; first, there may be a small fragment of bone, due to the original injury, which has passed unnoticed which is ingrained with dirt and may be ever so small yet sufficient to produce infection, while if it had been discovered at the time of injury and the bone been chiseled out where the dirt had been ground in, we could have avoided this trouble. It is always necessary where particles of dirt are seen in the end of the bone fragments to use chisel and cut that portion of bone away, as it is the only safe and sure way of getting all the particles of dirt from the fragments. On the other hand, this trouble may arise from a necrosis due to an injury of the periosteum at the time the scalp wound was received.

One other cause must not be overlooked which is more liable to occur in old people than in young, and that is erysipelas of the face and scalp which is liable to set up thrombosis of the veins which may extend into the cranium thereby carrying the streptococcus into the membranes and possibly into the brain itself, so we can see how necessary it is to be very careful even in the slight scalp wounds. We should pursue the most profound caution in the treatment of all such cases as the danger arising therefrom is not to be over estimated.

My aim in this paper has been to point out the importance of making a correct diagnosis of injuries to the head; and second, the vital importance of immediate operation if fracture exists, also of close observation of the most trivial wounds of the scalp.

DISCUSSION.

Dr. Warren : Time is passing so rapidly that I do not think I can add anything to this very excellent paper.

Dr. Allen : This excellent paper brings to my mind many points. It is so necessary to make a thorough examination. I would like to ask the author of the paper, why, in the first case, he did not operate if the patient was liable to suffer from the symptoms of Jacksonian epilepsy or locomotor ataxia. Was he not justified in operating in order to give the patient every possible chance ?

Dr. Hartman : Answering Dr. Allen's question, there was one very good reason. The man's physical condition was such that I did not consider operating would be wise, and the second reason was that we could not get the patient's consent. There was an accident insurance in this matter whereby, from my statement, he received \$5,000. After he got the \$5,000 he got out of my sight and that was the end of it.

FRACTURE OF THE PATELLA.

BY GEO. E. MAY, M. D., NEWTON CENTRE, MASS.

This paper is no attempt at an exhaustive treatment of the subject of fracture of the patella, but having managed two cases by different methods I am prompted to bring the subject to your attention with the hope that some discussion may be aroused.

Case I. Mrs. B., age 35, weighing about 180 pounds, while alighting from a carriage threw her weight suddenly upon the left lower extremity while in an extended position and fractured the patella.

I saw her at once and immediately controlled the muscles of the thigh by a firm bandage, applied a posterior splint, elevated the foot and applied an ice bag to the knee. There was a separation of at least three-fourths of an inch between the fragments.

In about five days the inflammatory symptoms had largely subsided and I approximated the fragments by means of the adhesive strips above and below, as is commonly taught in the text books, maintaining extension by the posterior splint and keeping the foot well elevated.

I found little apparent difficulty in bringing the fragments into apposition or in holding them, and after eight weeks of this treatment—the last five of which had been modified by substitution of a plaster cast from toes to groin—all dressings were removed and careful passive motions of the knee joint begun. I at first flattered myself that I had obtained bony union, so slight was the deformity in contour of the patella, but the lower fragment had become firmly anchy-

losed to the underlying structures and the most careful attempts at flexion of the knee soon showed me that there would eventually be a separation of the fragments. This was perhaps increased by some carelessness on the part of the patient, and at present, about four years after the accident a separation of at least one inch has occurred, although the patient a very active woman, has seemingly no discomfort whatever.

Case II. William M., aged 24, while attempting to escape from the police fell into a sewer excavation and fractured the patella. He came into my service at the Newton Hospital, and on the following day, after due consultation, I advised operation, and assisted by Dr. Perkins, proceeded to repair the injury by a slight modification of Watson's method. The fragments were exposed by a curved incision with the convexity downward. The joint was carefully washed of clots and fibrin by sterile salt solution. The fragments were well trimmed, each was drilled parallel to the long axis of its fractured surface, and a heavy, braided silk ligature was passed through. Another ligature was made to encircle the patella, passing through the ligamentum patellæ below and the quadriceps extensor tendon above. When these ligatures were snugly drawn and tied the approximation of fragments seemed perfect. The capsule was carefully stitched over the joint and the external wound closed. It is needless to say that careful aseptic methods were followed throughout. The limb was placed on a posterior splint and the foot well elevated.

There was a great deal of œdema and no small amount of pain attendant upon the first week following the operation, and I am sorry to say slight suppuration occurred, but it was fortunately confined to the integument and rapidly subsided under a phenyl pack.

A plaster cast, fenestrated at the knee, was applied as soon as inflammatory symptoms subsided and passive motion carefully begun at the end of the seventh week.

The results in this case seemed all that could be desired so long as the patient remained under observation, but I regret to say that I cannot give his present condition, his whereabouts being unknown.

I believe the question of operative or non-operative treatment of this injury is still far from being conclusively settled. Modern surgical methods are inviting us into every part of the human anatomy, and yet are we warranted in opening every knee and exposing it to infection when many excellent results come from more conservative methods?

Powers, in 1898, before the American Surgical Society, reported a collection of seven hundred and eighty-six (786) cases of operation for simple fractures of the patella. Of these seven hundred and thirty-three (733) were successful, thirty-nine (39) resulted in marked stiffness and deformity, one (1) required amputation, and thirteen (13) died.

I believe that any such group of facts should make us reflect before declaring, as some surgeons have done, that the open method with suture was the only scientific method of treatment. When a mortality of nearly (2) per cent attends an operation done simply for preserving the usefulness of a limb which very likely would be useful without the operation, we must say that the measure is not to be lightly undertaken. I believe the operation has a place among surgical procedures but I would limit it to,—

1st. Such surgeons as have at command the most admirable facilities for strict asepsis.

2nd. To such recent cases as with tilting or comminuted fragments do not promise to coapt under mechanical methods, or

3rd. To such old cases as have such widely separated fragments after mechanical treatment as to seriously impair the usefulness of the limb.

In case the operation is done at all, I believe the following points worthy of consideration.

First. In making the skin incision, if it be carried well down over the ligamentum patellæ and then the large flap dissected up to the line of fracture before opening the capsule, we have provided against any ready communication between the joint and the external wound in case suppuration should occur in the latter.

Second. By the method described above in report of case II. I believe as firm a union may be secured as by any method yet reported, the sutures being much less likely to cut out then when placed transversely to the long axis of fracture.

Third. Several operators of late simply suture the capsule with chromicized gut and take no bony sutures whatever in recent cases when the separation is slight.

Fourth. In old cases of widely separated fragments the greatest difficulty may be experienced in bringing them together and very substantial suturing must be employed. Often the quadriceps muscle must be divided in order to approximate.

Fifth. I think it would have been much better in my case, and I think it is generally advisable, to wait before operating for at least a week or until inflammatory symptoms have largely subsided.

Sixth. The occupation of the patient may have some influence on the question of operative measures, person of leisure or sedentary occupations of course being less inconvenienced in case separation of the fragments persists.

THE PRESENT STATUS OF THE SURGICAL TREATMENT OF SALPINGITIS.

BY GEORGE R. SOUTHWICK, M. D., BOSTON, MASS.

Conservatism rather than radicalism is the keynote of modern gynecology and nowhere has this principle been more emphasized than in the treatment of salpingitis. The mere presence of this disease is not an indication for operation. Many acute cases undergo resolution and cure with appropriate treatment. This is especially true when the tube is distended by non-septic material and the writer has seen recovery even in severe cases following gonorrhoea. These facts warrant delay in operating for acute salpingitis unless urgent symptoms are present. Pyosalpinx, pus in the Fallopian tube, very often requires surgical aid and the problem is not so much how to remove the pus, but rather how to treat the case with the least mutilation of the patient.

Bacteria and their toxins are the cause of suppuration and the abscess grows only when they are present.* With the death of the bacteria the production of toxin ceases. The pus becomes sterile and we have water, leucocytes and a little degenerated tissue surrounded by the protecting zone of small cell infiltration which has compressed somewhat the blood and lymphatic vessels so that resolution and repair proceed slowly. The immediate examination of the contents of the tube before closing the abdomen was undertaken at Johns Hopkins for the purpose of determining the necessity of drainage of the peritoneum, and elsewhere for scientific purposes. Pathogenetic, i. e., virulent bacteria are rarely present† and further investigation has shown that with few exceptions the bacteria in the pus of a pyosalpinx disappear in a few months; some believe in three months, others give an average of nine from the formation to the sterility of the pus.‡ Bacteria confined encapsuled in closed cavities soon lose their virulence and die from their own products—the toxins. This explains why there is considerable less danger in operating on chronic than acute cases. This important clinical fact has done much to limit a drainage which seldom drains and often provides a path for infection. It has led indirectly to the dry method of operating with sterile packing about the field of operation with sterile gauze in the Trendelenberg position and, if necessary, completing the peritoneal toilette with copious flushing with sterile salt solution and drainage through the lymphatics by Clark's method rather than by ordinary drainage.

The impunity with which very considerable collections of pus in the tubes can be treated has led to various attempts at surgical repair

*Ziegler, *General Pathology*, p. 300, 1898.

†Gebhard, *Pathologische Anatomie*, p. 442, 1899.

‡Kiefer, *Centralblatt für Gynäkologie*, No. 42, 1896.

without removal of the tubes, which has been lightly termed gynaecological millinery, but in spite of such pleasantry it is more than possible that such conservative surgery, aided by the microscope and bacteriological diagnosis, may yet open a new field for the gynaecologist. If the contents of the tube are known to be sterile, why is it not logical to empty the tube, irrigate it and close the incision with a Lembert suture; or, if the organic changes are very pronounced at the outer extremity of the tube, to resect it and unite the mucosa and peritoneum so as to make a new orifice and preserve the ovary whenever possible, though suspension of the latter may be necessary. This already has been attempted with some degree of success,* but the extensive pathological changes usually present have led most surgeons to believe that such an effort to obtain repair is useless and a waste of time. As a matter of fact, the ultimate results of conservatism of this kind have shown many failures and the necessity for a second operation. Until better results are obtained, drainage of a pyosalpinx and conservation of the tube is liable to require a second operation.

The treatment of a comparatively healthy tube and ovary on the opposite side is still disputed, as experience has shown that many such cases require a subsequent operation if both tubes and ovaries are not removed, but with a better knowledge of the etiology of salpingitis there is an increasing tendency to leave the second tube and ovary and take more pains with the disinfection of the vagina and the uterine cavity.

The question of choice between the ventral or vaginal method occupies debatable ground, which is not fully covered by allowing the conditions present to determine the choice of operation. In a general way it may be said that when these conditions absolutely preclude all attempts to preserve intact some part of the tube or ovary the vaginal operation is in order, as when there is bi-lateral salpingitis and ovaritis.

The advantages of the radical vaginal operation have been fairly stated† as follows :

- 1, The patient consents more willingly to the operation.
- 2, It is possible to remove at the same time the smaller and harmless new growths, without waiting until the growths become unbearable on account of their dimensions, or until inflammatory adhesions, suppuration, or malignant degeneration occur.
- 3, Diminished chances of infection.
- 4, The possibility of operating under less favorable conditions.

*Dudley, *American Gynæcological and Obstetrical Journal*, Feb., 1897.

* " " " " " " " " Oct., 1898.

* " **American Journal of Obsetrics, Vol., 37, No. 1, 1898.**

†Deutsch Medizinal Zeitung, Aug. 10, 1899.

5, Diminished mechanical irritation of the intestines and parietal peritoneum by the hands of the operator and his assistants, sponges, instruments, sheets, etc., which come in direct contact with the peritoneal cavity.

6, Diminished danger in cases of flow of the purulent contents from the torn sack of the new growth.

7, More satisfactory post operative course of the case and speedy convalescence.

8, Absence of danger of ventral hernia and no need of an abdominal binder.

9, The possibility of doing bodily work soon after the operation.

10, Diminished mortality.

These advantages are fairly stated and yet the one great disadvantage outweighs nearly all of them, *i. e.*, vaginal hysterectomy precludes conservative surgery. The ease and success with which this operation can be performed in a large number of cases makes this operation par excellence the temptation of skill, and no record will be published of the victims of such radical treatment.

The recent report of Schauta* is a powerful argument in favor of the vaginal method and is markedly confirmatory of the earlier report of Landau, but it must be remembered that a large proportion of these abdominal operations were performed by older methods which do not compare with the modern ones now used by progressive operators, and his statistics do not admit of accurate comparison with the most recent methods. His paper is chiefly valuable as it deals with the permanent results following operations. It is only fair to concede preference to that method which favors the lowest mortality with the largest percentage of permanent recoveries. Applying this principle to 549 cases we have,

	Mortality %.	Permanent recovery %.
Vaginal radical operation,	2.7	86.8
Abdominal radical operation,	10.5	81.0
Vaginal unilateral adnexa operation,	14.2	22.2
Abdominal " " "		
with extirpation of the uterus,	0.0	50.0
Abdominal bi-lateral adnexa operation,	6.9	59.8

This means that complete extirpation of both the uterus and the adnexa, preferably by the vagina, gives a lower mortality and a larger percentage of cures than any of the so-called conservative methods. A statement which would be open to some question in spite of the large number of cases reported, which may be summed up as follows :

*Archiv für Gynäkologie. Bd., LIX. H. 1, 1899.

	Method of operation.	Number.	Cured.	Mortality %.
ABDOMINAL.	Unilateral removal of the appendages,	20	19	5.00.
	Bi-lateral " " "	286	266	6.90.
	" " " "			
	with extirpation of the uterus. (abdominal radical operation)	38	34	10.50.
	Total abdominal operations on the appendages,	344	319	7.20.
VAGINAL.	Unilateral removal of the appendages,	21	18	14.20.
	" " " "			
	with extirpation of the uterus,	7	7	0.00.
	Bi-lateral removal of the appendages,	1	1	0.00.
	" " " "			
	with extirpation of the uterus. (vaginal radical operation)	220	214	2.70.
	Total vaginal adnexa operations,	249	240	3.60.

Max Landau* reported from Jacob's clinic in Brussels and other sources (1626) laparotomies for chronic salpingitis with a mortality of 5.59% including 140 of Schauta's cases just reported, and he preferred the radical vaginal operation.

A more careful examination of this report shows that a considerable number of the cases were not purulent and many were operated on before 1890. It is only fair to claim that, with methods now used, the rate of mortality, (5.59%) would materially diminish, though Schauta reports 7.20% in 344 similar operations, nearly all of which were pus cases. It is only fair to state by way of contrast that Leopold Landau† reported soon after, 141 cases of vaginal hysterectomy with a mortality of 2.80%, yet he could estimate only 60-70% of perfect recoveries which is a different matter from recovery from the operation. This is the reason why many surgeons refuse to accept this operation as perfect. The mortality rate was low but not much more than half of the cases were really cured. A later report from L. Landau's clinic of 200 cases of vaginal hysterectomy for purulent disease of the appendages with a mortality of 4% showed better ultimate recoveries and many of the best German operators still endorse total vaginal hysterectomy as the operation of choice for pyosalpinx.

The French method of bi-secting the uterus is now universally known and practised with minor modifications by individual operators. The clamp allows better drainage than the ligature, and is better

*Archiv für Gynäkologie Vol. XLVI, H. I, p. 101, 1894.

†Archiv für Gynäkologie, Bd., XLVI, H. 3, p. 397, 1894.

‡Mainzer, Archiv, für Gynäkologie, Bd., LIV, H., 3, p., 421, 1897.

†P. Brose Zeitschrift für Geburtshilfe und Gynäkologie, Vol. XLI, H., 2, p. 175, 1899.

Also Bliessener, Monatsschrift für Geburtshilfe u. Gynäkologie, Vols. 3 and 4, 1896.

Also Cohn, Archiv für Gynäkologie, Vol. LIX, H. 1, p. 24, 1899. and Dührsen, *ibid*, Vol. XLIX.

adapted to those cases of extensive pelvic suppuration. Whether the angiotribe or the electric clamp will prove another step in advance remains to be seen. It is reasonable to believe that a method which is secure from hemorrhage, and at the same time does away with both clamps and ligatures, will be a step in advance. Until there is much experience demonstrating their safety, the writer believes the surgeon will rest more easily with the knowledge that a reliable ligature constricts the divided arteries of his patient.

The treatment of large accumulations of pus by vaginal incision and drainage is better restricted to cases of pelvic abscess pointing in the vagina, and even here it is often far wiser to perform hysterectomy and be sure of securing adequate drainage.

The trend of professional opinion is again toward the abdominal method, for the simple reason that it gives the patient every possible chance for conservative surgery and at the same time every opportunity for radical treatment as well. It also gives the operator a better chance to examine the condition of the appendix which sometimes complicates a salpingitis of the right side. Salpingitis and appendicitis co-exist more often than has been believed, and the question of the advisability of examining the appendix as a routine procedure in laparotomy is under serious consideration.

At the International Congress of Gynecology and Obstetrics in Amsterdam last August Dr. Hartmann* of Paris in his paper on The Operative treatment of Salpingitis, stated that he would absolutely reject the vaginal route for inflammations of the adnexa, save that posterior colpotomy was still indicated for large and easily accessible collections; this, moreover, in many cases would have to be followed by a complete abdominal operation. Similar opinions were expressed by Faure and Duret.

No one set of rules can be or should be formulated for the treatment of salpingitis. The operator of today calls to aid the practical application of modern pathology and bacteriology and a broad knowledge of the work of his confreres. He wisely declines to follow any rule of thumb, and elects to be a law unto himself.

DISCUSSION.

Dr. Walter Wesselhoeft: I have nothing to say on the subject. I am rather taken back to find that I am on the paper. I am the only one in this large assembly who knows nothing at all about the subject. If I have a case of this kind I immediately call a surgeon who knows more about it than I do.

Dr. Sarah E. Sherman: Mr. Chairman, Members of the Society, I was asked to suggest something for this meeting, and I suggested

*New York Medical Record, Sept. 30, 1899.

this subject, not that I had anything to say myself, but that I might hear what others might say about it. One thing struck me in regard to this subject, that is, so many cures have been made without surgical help, as remarked by many. That has not been my experience as a rule. I always try the conservative methods first, but where there has been septic material my cases have not recovered without the aid of the surgeon. I should say as a rule, that the removal of the ovary and tubes or uterus is necessary to get rid of the annoying symptoms. I have in mind a case. We decided to operate. I recommended her coming to our hospital here in Boston, but the members of the family felt she could not be spared to come to Boston. The uterus was left where it was, and ever since the operation there has been constant trouble with that organ. So far as my little experience would go, I should always be in favor of as early operation as possible, and that as radical as would be considered proper under the circumstances. I feel very grateful to Dr. Southwick for making this matter so plain.

OSTEOMYELITIS.

BY CHARLES H. THOMAS, M. D., CAMBRIDGE, MASS.

There are many terms used to designate this affection of the bone, but none more simple and still sufficiently explicit as bone abscess which it certainly is. The disease more frequently occurs during the formative period of life and is quite rare in adults, excepting, perhaps, the traumatic variety. It usually affects the long bones, preferably those of the lower extremity, especially the femur, and at its lower end near the knee joint. Why this is so, authorities are silent. No doubt exists of its being an infectious disease as Pasteur discovered a micro-organism in the discharge from an acute suppurative osteomyelitis, identical with that present in furuncles. The primary infection and suppuration begins in the medullary substance due to invasion through the nutrient canals from a suppurating wound elsewhere, or through the respiratory or intestinal tract, or from exposure to cold, especially by bathing in cold water.

The clinical symptoms of osteomyelitis are chill, pain, tenderness and swelling over the affected area; high temperature, rapid pulse, diarrhoea, delirium of a typhoidal type, dry tongue, thirst, and in some instances, bronchial irritation.

In order to arrive at an early diagnosis, every factor having the least bearing upon the case must be duly considered and carefully analyzed,

as there are several diseases presenting a very close resemblance to the clinical picture of a bone abscess, and a differential diagnosis is reached sooner by exclusion than by any other method.

Osteomyelitis.	Typhoid fever.	Meningitis.
1. Essentially an affection of childhood.	1. All ages susceptible.	1. Frequent in children.
2. Pain, swelling, redness over a long bone near a joint; affected limb flexed.	2. No pain, localized swelling or tenderness in the long bone.	2. Rolling and squinting of the eyes; pupils dilated.
3. Delirium early in attack. Diarrhoea present in the first stages.	3. Delirium and diarrhoea rather late in the disease.	3. Headache; rolling of the head; vertigo.
4. Temperature continuous, but not high.	4. Temperature fluctuating; evening exacerbations.	4. Convulsions followed by stupor.

The following case will serve to illustrate how easily it is to be mistaken, notwithstanding the apparent clearness of the symptoms presented :

Edward M., age 12, went in bathing July 4th, 1898, remaining in the water (fresh) about one hour. On July 11th his father requested a prescription for what he considered an attack of rheumatism, saying his son's left knee was swollen. He was feverish and at times mildly delirious.

Prescriptions were given on the 16th and 17th following, as there was no improvement. The patient was visited on the 18th and his condition was as follows : Delirium, attempting to get out of bed; temperature 103.8°; pulse 126; very hyperæsthetic to noise, light and motion; pupils dilated; diarrhoea; continually crying for food, ice-cream and ice water; swelling above the left knee which was red and very sensitive to pressure; leg flexed; heavily brown coated tongue and offensive breath.

He was sent to the hospital with the diagnosis of probably typhoid fever. Stramonium was the remedy prescribed, and a cold water compress to the part affected. Later diagnoses of rheumatic meningitis and tuberculosis of the knee joint were made. Up to this time no fluctuation could be detected positively, but became apparent after the application of poultices.

The abscess was finally opened, showing an attack of osteomyelitis beyond question. The recovery, although somewhat prolonged, was complete, with motor functions normal.

Regarding the treatment of acute osteomyelitis, the sooner the pus is evacuated by a free incision down upon and into the bone abscess, the better will be the results; otherwise a condition of chronic osteomyelitis will supervene with the production of pathological lesions elsewhere and a prolongation of the period of convalescence.

DISCUSSION.

Dr. J. K. Warren:—Dr. Thomas in his very excellent paper has given us the gist of this whole matter in a nutshell, and yet the subject is so vast that it admits of almost endless discussion. This disease attacks usually the middle portion of the long bones. In adults it may occur almost anywhere, but in children it is usually confined to the end or the spongy part of the bone. For this there is an anatomical reason, and also why it occurs more frequently in children than in adults. The reason that boys are more liable is that they are more exposed to traumatic injuries. Until the ossification of the bones is complete, the ends are in a constant state of congestion. There are large numbers of capillaries which are imperfect and incomplete, and these act as sort of cups or sinuses which retain the blood. Again, the capillaries in this part of the bone, those that are complete and established, are about four times as large as the arteries which supply them, which of course diminishes very much the force of the blood stream. The blood stream being diminished, it gives the chance not only to filter out material for building up new bone, but germs as well. This seems to be a sort of happy hunting ground for all sorts of germs. All forms of cocci are found from discharges coming from osteomyelitis. The same condition occurs to a certain degree in cases of fracture. There is in this case stagnation of blood, so that the force of the blood stream is retarded, and this allows the germs to find a place for lodgment. There is nothing like the number of cases of osteomyelitis that there were in the old Mercurial days. It was very common then, after fevers, to have bone sores, which was nothing more nor less than osteomyelitis.

In regard to the diagnosis of osteomyelitis, typical cases are easily diagnosed. The author of the paper has given you a very clear differential diagnosis between osteomyelitis and kindred difficulties. It is not always clear, however. We arrive at a diagnosis by the process of exclusion. There is one symptom which he did not mention, or if he did it escaped my notice. That is, the sound on percussion. If you expect osteomyelitis to be present, if you percuss the bone very lightly, you produce the same impression that is noticed on a tooth that is inflamed or ulcerated.

Dr. Richardson:—I regret as much as you do the necessity of interrupting this most interesting bureau report, and I would suggest that we proceed to the business which I understand is to come before the Society, and should there be any time thereafter, I am sure we should all be very glad to have the report resumed.

Dr. Gardner:—I can frankly say that we never had such a limited knowledge about any disease as the present one. I wish to say that, the disease being seated beneath the periosteum, I do not at all doubt

that many people die in the first stage of the disease from the effect upon the nervous system of the patient. I wish to impress upon the mind of physicians that, if there is any doubt in their minds as to whether it is osteomyelitis or not, the importance of making an exploratory incision, because an early examination often obviates a great deal of trouble. The sooner the operation is performed, and the sooner the diseased bone is taken out the sooner is the pain removed, and the patient's chances enhanced.

GOOD HEALTH WITHOUT A GALL BLADDER.

BY F. A. HODGDON, M. D., MALDEN, MASS.

Mrs. L., aged 65 years, five years ago last Nov. (1894,) had a long continued, persistent pain on the right side of the bowels. The physician in charge made the diagnosis of neuralgia of the bowels.

She went on to a very good recovery and for the next four and a half years enjoyed a fair degree of health. But on the morning of May 26 last, at 2 A. M., I was summoned in haste to the bedside of this same patient. I found a history of a marked chill and extreme pain, the patient groaning at every breath. Very tender over the entire right side, extending from the right inguinal to the right hypochondriac regions; vomiting of food and mucus.

So persistent was this vomiting that the usual remedies did not abate it one particle. Temp. 102, pulse 110.

I made the diagnosis of appendicitis and it was confirmed by a surgeon called in consultation. We made all preparations for an operation when all symptoms abated as suddenly as they came on. Temp., vomiting, pain, all subsided, and the patient went on to an apparent recovery.

On June 26 these symptoms all returned in a decidedly aggravated form. This time the pain was better localized and a diagnosis of hepatic abscess made. Of course gall stones were the cause of this abscess as we thought, and on June 28 I had her admitted to the Malden Hospital, and on July 14 the operation took place. Dr. Prior, who was there on service, did the operation. After making the usual incision we came down upon a distended gall bladder. Upon aspiration pus and not bile issued forth. Nearly 2 oz. was taken from the gall bladder.

Passing down to the cystic duct a large tumor was found which could neither be crushed nor pushed back into the gall bladder, which completely obstructed the passage of the cystic duct. An incision was made into the cystic duct and this stone taken out. This incis-

ion was carefully closed up and the gall bladder, now thoroughly opened and curetted, sewed into the muscular tissue upon either side of the wound. The gall bladder was packed with gauze and dressed open. The common duct was so bound down with adhesions that its course could with difficulty be made out.

The patient went on to an uneventful recovery, and is today in good health.

Some of the peculiar features of this case are, no bile was seen before, during, or after the operation. No jaundice ever was present. What became of the bile? Did it go direct through the common duct to the intestine, or was an artificial gall bladder formed by the pressure of bile in some other portion of the liver in the shape of a pocket? Why was there no jaundice? Could this stone have completely occluded the cystic duct for a period of five years without more periods of pain?

This case may have many counterparts, but to me it was unique in these respects. No jaundice, no periods of pain except those mentioned. No secretion of bile during all the process of healing. The gall bladder healed by adhesions and granulations and completely and solidly closed up. So that today we have a good healthy patient with the function of the gall bladder completely obliterated.

DISCUSSION.

Dr. Carl Crisand: I would like to ask Dr. Hodgdon if there was any diarrhœa.

Dr. Hodgdon: Never.

NON-INTERVENTION WITH THE KNIFE IN APPENDICITIS.

BY ELMER H. COPELAND, M. D., NORTHAMPTON, MASS.

We all of us meet, in our practice, with more or less cases of appendicitis. We study them carefully, treat them to the best of our knowledge and ability, and—what is the result? Recoveries with a few exceptions, varying from two to about twenty-five in every hundred, according to the skill, luck, and veracity of the one reporting.

It is with this varying remnant that we are concerned, that we may make it as small as possible. We must aim at perfection although well aware that our best efforts will at times be unavailing and the great conqueror of all will laugh at our brave struggle against him.

Let us suppose, then, that we have before us a case of appendicitis. Not to go into too much detail, we will simply mention the prominent symptoms: nausea, and perhaps vomiting—pain in the abdomen,

general or localized in the right ilio-cæcal region; tenderness at the McBurney point, perhaps a tumor; pulse 100-130: temperature around 100, possibly 103; bowels constipated. Not much doubt of the diagnosis — is there? Dr. Robert T. Morris says, "Appendicitis is as easy to diagnose as a broken leg." Whether we accept that statement or not, we will not doubt the diagnosis of our supposed case. Now, then, to operate or not to operate — that's the question.

Before we take the knife in hand, there are several thoughts that must give us pause. McBurney says, "There is no purely medical measure that will cure the disease"—then it must be a surgical disease and we "in with the knife."—Not so fast. McBurney is a good surgeon and undoubtedly has his points, but let us see what others say.

Van Hook says it is his positive conviction that one hundred cases of acute, perforating appendicitis will show a higher per cent of recoveries under medical treatment with incision of pointing abscesses, than will one hundred like cases operated upon by one hundred or even twenty surgeons who are gaining their first experience. Experienced surgeons are not always at hand in our small country towns; if we operate at once, it must be done by surgeons who are gaining their experience, and we have good authority for preferring medical treatment.

Operations for appendicitis have become so common in our section of Massachusetts, that in a neighboring town of less than ten thousand inhabitants one would-be-surgeon, but general practitioner, has performed one hundred operations for appendicitis in one year.

In our immediate locality, the operations have invariably been so successful and the patients have so uniformly died in about three days after, that the public is demanding of the doctor, "What is a successful operation?"

But why be in such haste to operate? Dr. G. F. Shrady says, "Do not operate if the pulse rate lessens, the pain diminishes and the temperature falls." These are named in the order of their importance; pulse first, pain second and temperature last.

Mayo Robson also says "The pulse rate is the guide to operation. If over 100 and increasing, operate." Here again is authority for delay. Wait and watch the pulse. Now that we have not an experienced surgeon at hand and that it would not be best to operate at once even if we had, what shall we do while we are waiting? Before we decide on that, let us briefly consider what is appendicitis. The name means simply an inflammation of the appendix — but what inflamed it?

"Bacteria," some say; "Traumatism," others. McBurney says, "Interference with the drainage of the appendix into the colon." Lane says, "Presence of fæcal matter or dried mucus in the appendix." After all has been said and due consideration given to each theory, it

seems to me that the most reasonable one is that which claims the trouble arises from some closure of the lumen of the appendix, thus causing an obstruction of the natural efforts of the appendix to drain itself into the colon. This is the theory advocated by McBurney, and Morris claims that the beginning of the infective appendicitis is catarrhal in origin.

Lane in the "Lancet" for July 25, 1896, says that constipation hinders the appendix from easily emptying itself into the colon and thus favors inflammatory conditions of the colon and the appendix.

It would seem that enough authority has been cited to substantiate the theory of the occlusion of the lumen of the appendix as at least a very common cause of appendicitis, if not the chief cause. But Gen. M. O. Terry of Utica, N. Y. puts the case even stronger when he says in a paper presented to the Association of Military Surgeons of U. S. in 1897 that "ninety-five per cent of the cases of appendicitis that come to the surgeon are due to vitiated physiology in the form of constipation."

Accepting, then, this theory that appendicitis is catarrhal in origin, becoming aggravated by closure of the lumen of the appendix, both conditions favored by constipation, what more natural course of treatment than that which should tend to relieve both these conditions? Such a treatment, I believe, is that promulgated by Gen. M. O. Terry. His plan of treatment will be given in his own words. Quoting from the article above referred to:

"The principles involved in the treatment of appendicitis by the non-operative plan are as follows: Catharsis, colon or high enema, fomentations with flax seed poultices and applications of hot sweet oil, the prolonged use of sweet oil taken internally, and a pultaceous diet.

It really does not matter what cathartics are used (each surgeon may have his own sweet dose) so long as the results are accomplished. My experience has led me to use, whenever possible, castor oil and sweet oil combined. The former is cathartic and the latter is soothing and relaxing to a congested mucous membrane, including the entire bowel tissue. The dose of the former must necessarily vary from half an ounce to an ounce and a half. Of the latter I give double the quantity of the former. The sweet oil should be continued in doses of from one ounce to a wine glass full followed by a glass of hot water, repeating the same every three to six hours according to degree of soreness and pain. But supposing the patient cannot take castor oil? If none of the mineral waters will produce the desired results give from five to ten grains of calomel with ten to twenty grains of bi-carbonate of soda dissolved in a glass of hot water, repeating every three hours until the desired result is obtained. I have never given more than twenty grains. At the same time however, it must be borne in mind that the external applications must be made of flaxseed

and hot sweet oil. Also that the enemas must be given without delay. At times I use three or four ounces of glycerine followed by soap and water. Then, again I use from half a pint to a pint of sweet oil followed by the enema. I always try to send the oil up as far as the ilio cæcal valve, for its relaxing effects, for this will assist in relieving pain.

It will be well in severe cases to place your patient in a Trendelenberg position. Sometimes it will be best to use the knee-chest position. *So long as there is any sensitive condition in the region of the appendix I continue the sweet oil, giving about half an ounce to a glass of hot water half an hour before meals three times a day.* The diet should be of oatmeal gruel (strained) milk with salt or peptonized and a free allowance of water."

This is the medical treatment that has been so successful in the hands of Dr. Terry that he has not lost a single case in forty-nine consecutive cases in five years and has operated only twice and he is a surgeon of acknowledged ability and as he himself says "is dependent upon surgery for a larger part of his income."

This paper has been written, not with the hope of imparting any information to any of our skilled and efficient surgeons or physicians, but with the hope of acquiring some information about this important disease. It is a matter of lives with us and not of opinions. In very truth, appendicitis, as it has come under my observation, either in my own practice or in that of my colleagues, as far as I have known, has been more successful under medical treatment apparently than under surgical.

No statistics have been gathered or attempted; this is simply a matter of impression as far as others are concerned; but I can recall only two cases in our vicinity that have been operated upon that recovered. One of these had to be re-operated upon to cure a hernia and the other case was that of Lewis Warner, our noted townsman, and you all undoubtedly remember that it was his hernia caused by operation for appendicitis that was one of the marks of identification that led to his capture. Every other case operated upon that has come to my knowledge, has been successful and — died. It has been my fortune, good or bad, to have had only one case of appendicitis to treat since hearing about this method. This was a mild case; the patient, a young woman about twenty. She was taken very suddenly in the afternoon of July 4th last. Pain in the abdomen rather general, gradually becoming located in the right side. When I was called at 7 P. M., there was fever 100; pulse 115-120; slight nausea and vomiting; bowels constipated. I ordered citrate of magnesia in full doses; saw her again at 10 P. M.; she had vomited the citrate, so gave her two tablespoonfuls of olive oil to be repeated every two hours through the night. She had a fairly comfortable night and in the morning two or three movements, very constipated. The temperature and

pulse were both slightly lower. Continued the sweet oil; the next day all the symptoms had improved, and in one week she was well. Previous to this attack she had always been constipated. I advised her to keep on taking from a teaspoonful to a tablespoonful of olive oil before each meal. She has had no trouble with constipation since, no return of the appendicitis, no tenderness in the abdomen. This case improved faster and was well sooner than any other case I have treated.

Right here I must make an interpolation, for on September 9, I was called to see this patient again at about six o'clock in the morning, she having been attacked with pain at the McBurney point at two o'clock that morning — had vomited several times and had one loose movement before I reached her. Temperature 99 4-5, pulse 96; pain and tenderness at the McBurney point, and a slight tumor. Ordered calomel 5 grs. with bi-carbonate of soda 10 grs. dissolved in hot water; this she threw off, so gave 2½ grs. calomel and 5 grs. bi-carbonate dry and repeated it in three hours; this she was able to retain. Also ordered simple soap injections which resulted in two free movements in half an hour, and the next day she had about a dozen watery actions. Monday morning she had normal pulse and temperature, and no more pain, but very little tenderness and no trouble since.

Another case has been under my observation this summer which had the oil treatment at the hands of another physician, in Newark, N. J. She recovered sufficiently in two weeks to come to Northampton. She has since had two slight recurrences; the last one early in Sept., when the temperature went to 100, and pulse to 109; pain and soreness at McBurney's point and a slight tumor could be made out. She had taken a Seidlitz powder the night before which resulted in two or three actions in the morning; however, I ordered one tablespoonful of castor oil with two of olive oil, and gave directions to repeat the olive oil every three hours; she having had no action at midnight the nurse repeated the castor oil with a result of five actions before I called at 9 A. M. the next day. At this visit the temperature was 98 2-5, and pulse 80; no pain and very little tenderness. A peculiar feature was that the last action of the bowels was composed of a few formed but not hardened fæces.

Shall this patient be operated upon now to prevent a serious recurrence?

In conclusion, let me state my position in regard to non-intervention with the knife. I believe that all cases of appendicitis should be watched carefully, and if possible, in conjunction with a skilled surgeon; and, in the period of watching, apply thoroughly this oil treatment of Dr. Terry's. If the pulse lessens, pain abates and temperature goes down, do not operate at once; and I believe that a large majority of the cases will show just such a lessening inside of twenty-four hours, under this treatment thoroughly carried out. If a few, now and then one, does not, we must operate; by so doing we may

save a life that would otherwise be lost. As to those cases, once cured, if they show a tendency to recur it is my belief that they should be operated upon in the interval, when they can have all the advantages of a hospital and the most skillful surgeons; but I do not believe in operating upon every case of appendicitis as soon as we are called. Wait a few hours and see if, under treatment the pulse does not begin to lessen. This must be borne in mind that it is the pulse we must watch most carefully; if it continues to rise, then prepare for an operation.

The advances in surgery and the splendid results in our almost perfect hospitals, have made physicians reckless until almost any doctor thinks he can operate as well as a skilled surgeon who has given his whole attention to operations, and these, too, performed under the most scrupulous cleanliness and in an atmosphere heated to almost the body temperature. Compare these facilities with those obtainable in an ordinary country home; compare our best surgeons operating in these best hospitals with our country cutters, as Van Hook says, "gaining their first experience."

One of our would-be-appendicitis-friends-with-a-knife, has said he would operate in a barn stable if his hands were clean. That is about all he knows about modern surgery.

An innovation in regard to luncheon was tried at this meeting. It was the feeling of the Executive Committee that a great deal of time had been wasted in going to and from luncheon in the past years, so they decided to try having a light luncheon served in the foyer of the hall, and thus take but half an hour from the scientific session.

**REPORT OF THE COMMITTEE ON OPHTHALMOLOGY,
OTOLOGY, RHINOLOGY, AND LARYNGOLOGY.**

GEORGE B. RICE, M. D., *Chairman.*

- I. "The use of X-ray in Locating Foreign Bodies in the Eye."
G. H. Talbot, M. D.
 - II. "Squint" D. W. Wells, M. D.
 - III. The result of Septal Deformities upon the upper Respiratory Tract.
E. R. Johnson, M. D.
-

**THE USE OF THE X-RAY IN LOCATING FOREIGN BODIES
IN THE EYE.**

BY GEO. H. TALBOT, M. D., BOSTON, MASS.

With the proper apparatus it is not only possible to determine the presence or absence of foreign bodies in the eye but to accurately locate them and estimate their size, even if they be so small as 1 or 2 mm. The difficulty in ordinary X-ray photography, is in correctly interpreting the result that is obtained in the negative; that is in localizing the foreign body in the surrounding tissues.

It is evident that if but one picture be taken, it will be impossible without some geometrical drawing to scale, to determine in what part of the path of the X-ray the foreign body casting the shadow is located. It may be very far anterior or very far posterior in the line of light, and the resulting pictures will be the same. Hence a cross photograph is necessary. But there must be some method of correctly reading these two pictures in order to determine the exact position of the foreign body; in other words some form of a localizing apparatus is essential.

Of several methods of locating these foreign bodies, I shall briefly describe two. The first, Dr. Sweet describes in the Transactions of the American Ophthalmological Society for 1897.

Mr. Collins of the Royal Ophthalmic Hospital of London, thus describes it, "Dr. Sweet fixes to the patient's head, an indicating apparatus carrying two steel rods, each with a rounded ball at the end. These two balls are placed at a known distance from the eyeball, one pointing to the center of the cornea and the other to the outer canthus, both parallel to the line of vision and perpendicular to the plate. From the relation of the images of these balls of the indicator, to that of the foreign body, he is able to work out on a horizontal and vertical diagrammatic section of the eyeball, the approximate position of the foreign body."

The method and apparatus devised by Mr. Mackenzie Davidson of London, is by far the most scientific and accurate of anything we have yet found. In localizing the shadows, he makes use of fine silk threads to trace the path of the Rontgen rays, which have produced two negatives at different points of view, and by their point of interception, can readily calculate the exact location of the foreign body.

Davidson's method is as follows: The patient sits upright, with the head resting against a board. Two knitting kneedles crossed at right angles, are enclosed in a square frame and brushed over with ink in order to mark the skin of the patient. The side of the head with the affected eye rests against these needles. A small piece of lead wire is attached to the lower lid by plaster, and projecting above, bears a definite relation to some landmark on the eyeball, such as a scar, or a pigment spot. A Crooke's tube is placed vertically on the opposite side of the head, at a measured distance from the point of intersection of the two wires, and slides on a horizontal bar parallel with one of the wires. A photographic plate, enclosed in a black envelope, is applied to the temple on the affected side. The patient is directed to gaze steadily at a distant object in a line parallel with the plate, that is, straight forward.

The tube is displaced a measured distance to one side, and an exposure made; then displaced to the other side, and another exposure made, either on the same plate or on a film that may be superimposed. The result is a negative that shows one image of the cross lines and two of the foreign body. After developing the negative, it is placed on the horizontal stage of the "localizer," which consists essentially of an adjustable horizontal bar, marked with a millimetre scale, starting from a central zero and notched correspondingly on the upper surface. A plate glass stage marked with a cross, of which the point of intersection lies exactly beneath the zero on the horizontal bar. Beneath this stage is a hinged reflector. As before said, the negative is placed film side up, on this stage, the shadows of the cross wires corresponding to the cross on the stage. The bar is raised or lowered so as to bring it to the same distance from the stage as the tube was from the sensitive plate when the exposure was made. Two silk threads are thrown over the bar and each one is fastened in a notch corresponding to the two different positions of the tube. The other end is threaded in a fine needle and fixed in a piece of lead. This line represents the path of the X-ray and is movable. One of these threaded needles is placed on any part of one of the shadows, and the other needle upon a corresponding part of the other.

It is obvious that where the lines touch and cross each other, there is the relative position of the foreign body. A perpendicular is now dropped from this intersection to the plate below and a mark made there. This is measured by a pair of compasses and indicates the distance of the foreign body from the surface. The distance of this

spot from the cross wires, represents the antero-posterior position. The precise position and direction of the body can thus be ascertained, as the cross wires are marked on the patient's skin, all exact data for localization are given. In order to measure the size of the body it can be quickly done by simply gauging the opposite sides of the shadows.

DISCUSSION.

Dr. D. W. Wells:—I have not seen this apparatus work, but I saw a case with Dr. Cheney at the Eye Infirmary a year ago, and with the aid of the ophthalmoscope we made out the body. We did not, however, succeed in finding it. It seems to me that if we cannot get it exactly in the sclera, it would be in a different place than it shows. In this particular case we could see the body plain enough, but when the incision was made, the foreign body was somewhere else.

Dr. Talbot: This was where the foreign body could not be seen. Usually the foreign body is imbedded in some of the tunics, and is not readily removable.

SQUINT.

BY DAVID W. WELLS, M. D., BOSTON, MASS.

Squint is the common name for Convergent Strabismus. By it is meant that condition in which the visual lines do not meet at the point "fixed." When one eye "fixes" or looks at a given point, the other eye turns in towards the nose. The squinting is usually confined to one eye, but it may be alternate. This condition must be distinguished from a paralysis of one or more of the ocular muscles, in which case the motion of the eye is limited in the field of action of the affected muscle.

In squint each eye separately is able to fix every part of the field. This is often spoken of as *Concomitant* Strabismus from the fact that it is an error of the *associated* movements of the eyes, for if the fixing eye is covered and the squinting eye is made to fix, it may be noticed that the sound eye converges to the same degree as did the squinting eye. This deviation may also be outward or vertical but this paper will be devoted to a consideration of the convergent form only.

Squint may be constant or intermittent, or only occasional—the result of some sudden emotion. The writer has a patient in whom the defect is not noticeable unless the subject is mentioned, when immediately the turning is very pronounced.

CLINICAL HISTORY.

The condition is seldom congenital. It is usually first noticed as a "cast in the eyes" when the child commences to play with small objects, perhaps only seen when he is tired or angry. It seldom becomes pronounced 'till three or five years of age.

It often follows Pertussis, Laryngitis Stridulous, Fright or other nervous shock. Seeing another person squint may mark its inception.

Although a permanent squint may be suddenly established without history of previous periodic attack it is doubtful if the previously mentioned precursors are more than exciting causes, the squint being the culmination of a pre-existing tendency. Once established, the condition generally remains permanent, although, in the language of Fuchs: * "In exceptional cases it happens that children with strabismus gradually cease squinting as they grow up and lose their strabismus about the age of puberty. They "outgrow" (so it is said) their squint. But the eye that has previously deviated is *left with its sight permanently weakened and accurate binocular vision is never restored.*"

This subject will be again referred to under the head of *treatment*.

The Etiology of Squint is a subject about which there is quite a diversity of opinion. The examination of the typical squinter at the age when the oculist is first consulted, viz. three to ten years, reveals the following conditions:

Hypermetropia, i. e. far sightedness or the shortened eye ball, one flattened posteriorly, is almost universal. If the latent form is included, (that is, hypermetropia which is made manifest only by a cycloplegic, i. e. a paralyzer of the accommodation,) it is present in ninety per cent of the cases.

Generally the vision of the squinting eye is less than the other, while Amblyopia, that is, defective vision which no glasses will correct, is often present. This may be due to a hazy cornea, following a former Keratitis, or there may be no discoverable lesion. Diplopia is never a symptom of a well established squint. The relative strength of the recti muscles may be normal, i. e. the adductors three times the abductors, or there may be a decided loss of abduction.

With these facts in mind, let us consider the various theories as to cause, Donders maintained that Hypermetropia was *the* sufficient factor in its production, the reverse condition, Myopia being the cause of Divergent Strabismus. It was well set forth that the excessive and constant accommodation of the hyperope exhausted the resources of the ciliary 'till finally binocular vision was sacrificed upon the discovery that excessive convergence augmented accommodation and relieved the over draft on this function. The relative strength of the adductors and abductors was thought to be of little moment. Naturally the occurrence of Hypermetropia in such a large proportion

* Text: Book of Ophthalmology '98.

of the cases gives color to this view, but the other fact is that Hypermetropia is the rule in children and only a small *minority* of children squint. Moreover Hypermetropia of high degree is not so common among strabismics as the medium amount, 2-3 D. The fact of the poor vision in so many squinting eyes was claimed to be due to a loss from disuse. "Amblyopia ex Anopsia."

But it is now held by the majority of competent observers that the Amblyopia *precedes* the squint. It is doubtful if there exists a true Amblyopia ex-anopsia. There is a suppression of the retinal image received by the squinting eye, otherwise a constant diplopia would exist. Excessive adduction is not sufficient as a cause since the relative strength of these two antagonistic forces *may* be normal. Defective innervation of the muscles has been assigned as a cause. It has been claimed that there is a differential innervation of the different fibres of each rectus muscle, but it would seem to be more scientific to reserve this practical begging of the question as a last resort.

If now, instead of trying to find a cause which will explain all cases, we divide the squint into four classes, it seems to the writer that a satisfactory explanation may be given for each.

1st. class.

Those in whom vision is normal in both eyes. Here it will be readily demonstrated that the abduction is relatively weak, so weak that the fusion power is unable to overcome the strong tendency inward. By this fusion power is meant that co-ordination which involuntarily turns the eyes so that the images fall on corresponding points of the two retinae, which is the *sine qua non* of binocular vision.

2nd. class.

Hypermetropic eyes will tend to squint if the adduction and abduction are normal (3-1), in order to relieve the excessive accommodative effort by a hyper-convergence. A difference in the refraction of the two eyes or the occurrence of astigmatism will, of course, augment the tendency. Volk claims that all hypermetropic cases that do not squint owe their salvation to an excessive abduction.

3rd. class.

The amblyopic eye squints because the fusion impulse is weakened or wanting. The eye has no incentive to inhibit the dynamic resultant of the muscles. Nothing short of an absolute balance of the muscle will keep this eye straight. The frequent development of squint in an eye which has become amblyopic from injury or haziness of the cornea is a sufficient demonstration of this principle.

4th. class.

Those abnormal eyes which are *apparently* crossed but which show no movement with the cover test. Here we have a macula relatively misplaced. Also cases for whom binocular vision is impossible, probably from some abnormality of the distribution of the crossed and

direct fibres of the chiasm. These cases may be diagnosed by the fact that with no combination of prisms can binocular vision be effected. The double images may be made to approach but a slight increase in the prism will throw the image to the other side. Fusion impulse is nil.

In most that has been written on this subject of etiology, it has been assumed that normal vision is present at birth. In the lower animals this is undoubtedly true. Not only do they almost immediately walk or run, but the co-ordination of the visual centres would seem to be at least sufficient to enable the animal to secure his food. As we advance in the animal scale toward man, there is evident a lengthening of the period of infancy, the significance of which has been very generally overlooked. It is this lengthening of the period of plasticity that emancipates, to a certain extent, the *young* of man from the thralldom of heredity; which enables him to mark out new paths of co-ordination in the jungle of the cerebral hemispheres. Preyer* says: "On the whole I have found that in the newly born, one eye very often moves independently of the other, and the turnings of the head take place in a direction opposite to that in which the eyes move. The unintentional character of both movements is plainly recognizable and the combination of the two is, at the beginning of life, accidental."

Priestly Smith† says: "All eyes are highly amblyopic at birth. Those which later reach the standard of normal vision do so by a process which occupies several years." These facts bear strongly on etiology and treatment.

Any defect, either in refraction or visual preception or muscle balance, may start the child on wrong lines and the fusion impulse may never be realized. This early suppression may cause a true amblyopia ex anopsia, but not in the old sense, that is, it is not the loss of a faculty once possessed but an arrested development.

Treatment.

Etiology has been entered into at some length because without a thorough understanding of the factors which have produced the condition intelligent treatment is impossible.‡ "Binocular vision is essentially a cerebral function," and while the fusion co-ordination is ordinarily involuntary, yet it is truly surprising to what extent one may control this and disassociate his convergence and accommodation by practice. The familiar example of the suppression of one image when using a monocular microscope is very suggestive of the possibilities of restoration of binocular vision by proper training.

The first and foremost indication is to determine the total refractive error. A thorough course with a cycloplegic, preferably

* W. Preyer: "Senses of the Will." Jena, 1884.

† British Med. Journal, July 2, '96.

‡ Noyes: "Diseases of the Eye," New York '94.

Atrop. Sulph. gr. *j* ad dr. *ij* gtt. *j* once daily must be instituted and continued for at least ten days, and in some cases I have used it a month. It may be necessary to repeat the instillation at intervals should there be recurrence of spasm. Glasses may be ordered of full strength, that is, equal to the total Hypermetropia but, a gradual working up to the strongest is better borne by the patient. With a very young child, glasses are impracticable, but with a three year old I do not hesitate to order them. The "golden opportunity" is while the squint is still periodic and has not passed over into the permanent form.

As previously stated, the refractive error may not be excessive and one should not hesitate to order the correction because it seems slight, for even a slight amount may turn the scale in a case in which the fusion function is weak. Prisms, base out, may often be advantageously combined and gradually reduced if possible. It sometimes happens that, as soon as the glasses are put before the eyes, an immediate straightening takes place, and the reduction of the deviation by a third or a half is not at all uncommon.

The "educative" treatment consists in first compelling the use of the squinting eye by a bandage or pad used over the fixing eye for repeated periods of an hour or two every day. The child will rebel some against this and may at first find some difficulty in walking and estimating distances, but perseverance will usually be rewarded with great improvement in both vision and in fixing power. This method has the advantage of being applicable to the youngest child. If the child has learned to read the desire for fusion can be cultivated and strengthened by arranging a vertical obstruction in the median line about half way between the book and face. A lead pencil answers the purpose very well. If one eye be closed, this will cut off about six letters of ordinary type, and unless one uses both eyes he will not be able to see behind the pencil.

Binocular vision exists in all degrees of perfection, and it is not necessarily secured because the eyes are properly fixed. The head, book and pencil must not be moved and by closing the eyes alternately it will be discovered that each can look behind the pencil about half an inch, that is the fields of the right and left eyes overlap. The instant every letter in a line can be seen binocular vision is secured. For an older patient this is a rather pleasant occupation, and if the matter read be somewhat interesting an extra stimulus to fusion is given.

Stereoscopic pictures have been so devised that fusion is necessary to see the whole picture. If this be impossible, suitable prisms may be placed in the stereoscope to assist. These are to be replaced with weaker ones as the faculty improves. All of these educative measures require time and patience.

In the line of *Materia Medica*, Norton tells us that, "The use of remedies has, in the early stages of many cases, relieved the tendency

to permanent strabismus." He mentions particularly, *Cicuta vir.* and *Jaborandi*. The writer has no personal experience in this line to offer, but suggests that it is our duty to first seek and remove the "mechanical" cause, and supplement with medicine.

If, after reasonable treatment, all these measures prove ineffectual, recourse should be had to an operation. This is either a tenotomy of the strong muscle or a shortening of the weak one. Tenotomy is a comparatively simple operation to execute but furnishes an opportunity for the exercise of considerable judgment. The operation for advancement is much more difficult and the result not so easily gauged. Undoubtedly more attention should be given to the weak muscle. Taking a tuck in the tendon has the advantage of not interfering with the attachment, with the chance of subsequent stretching. An instrument called a tendon tucker has been devised by Dr. Greene of Grand Rapids, Michigan. It consists of a pair of forceps with ends bent at right angles, one jaw sliding over the other. This enables one to tuck the tendon to any desired amount, and hold it in position while sutures are being applied. When the conjunctiva is closed over this, a decided bunch is apparent but this soon disappears.

In closing, just a word of caution. It is certainly bad practice to advise waiting to see if the child will not outgrow the trouble. To repeat a statement previously quoted from Fuchs: "In exceptional cases it happens that children with strabismus gradually cease squinting as they grow up, but the eye that was previously deviated is left with its sight permanently weakened, and accurate binocular vision is never restored."

DISCUSSION.

Dr. Geo. A. Sufra: In opening this discussion I realize that the subject is an old one, but one upon which much can be very profitably said. The early recognition of this condition, while it is yet in the incipency, and its proper treatment, are of the utmost importance. And it is in this early stage that the public, and many times the general practitioner, has an erroneous idea, and I am sorry to say, too often treated indifferently by the specialist.

To illustrate what can be done by proper treatment, and what takes place by improper methods, I will cite two cases. The first one having been examined by Dr. Wells when the deviation was periodic, when the child became tired, irritable or attempted to look at a near-by object, at this time six dioptres of far-sightedness was present. Lenses were ordered to correct the visual error, but the parents objected to their use, thinking it hard to put lenses on a child so young. An old school oculist was consulted, who, after examination stated that glasses were not necessary, and dismissed the case. After having received advice from so eminent an authority, which suited so well the wishes of the parents, they went home happy in the delusion that

all would end well. About one year later I was called upon by Dr. Wells to examine the case, as the parents were still in doubt about the necessity of wearing lenses, but were finally persuaded to give them a trial, as the squint had become permanent. At the present time, after six months use of lenses, Dr. Wells informs me that the squint has become periodic, but that a high degree of esophoria, a tendency to deviate inward, is still present, and as the total error of refraction has been corrected, a tenotomy will be necessary before muscular balance is established.

Case 2. Under treatment at present, showed far-sightedness of six dioptries with marked astigmatism in addition. Periodic strabismus is present without the correcting lenses; with the correcting lenses, only 10 degrees of esophoria show, and I feel confident that practically perfect muscular balance will be established in this case if the proper lenses are worn. The points I wish to bring out and emphasize in comparing these two cases are the necessity of early recognition, and proper treatment, and to correct the impression which still exists, that time will correct the trouble. Unless these cases are properly treated, muscular irregularities with their attending evils, or actual squint are bound to follow.

THE RESULT OF SEPTAL DEFORMITIES UPON THE UPPER RESPIRATORY TRACT.

BY E. R. JOHNSON, M. D., WOLLASTON, MASS.

Like the author of a book, the writer of this paper believes there are very good reasons for considering this subject. The general practitioner from time immemorial has been seeking a specific for what he was pleased to call catarrh. The patent-medicine man has blossomed forth at regular intervals and announced to the world at large, that he has found a specific for this dire disease, which, he claims, has so far baffled the skill of the authorities. To such a large degree indeed has the faithful physician and the pretender alike, been unsuccessful in his attempts to cure inflammation of the upper respiratory tract, that the laity in general are still looking for a specific.

Like the legend of the youth, who in his enthusiasm seeking the temple of fame, travelled out of the plain of his every day life, forsook all else and spent the years of his life toiling up the steep mountain in order to reach the temple. At last, aged and weary, he attained the height and looking eagerly about him for his treasure, saw no temple; and wandering on he met an old man, who looking sadly at him, appreciating his earnest and worthy efforts, but pitying his mistake said: "My friend, the temple you seek stands in the midst of the

place you have left." This is exactly what will greet him, who for a lifetime seeks a specific for any pathological process, except he confine his study to the local condition, seeking first diligently the cause and then considering his remedy.

For the past few years we have been making rapid strides in our knowledge of diseased conditions in all parts of the body. The nose and throat have received their share of attention. The third tonsil and its evils have been portrayed again and again, but more rarely have we heard of septal deformities and their sequelæ.

On account of the position and structure of the septum, it is subject to many alterations and thereby exciting many pathological conditions. It is formed by a cartilaginous portion somewhat quadrilateral in form, the perpendicular plate of the ethmoid and the vomer. These are united at their edges by a fibrinous membrane, the perichondrium, forming a continuous, smooth inner wall to each canal. The Schneiderian membrane covers the entire septum, thickest nearly opposite the anterior third of the middle turbinate, including at this point a small amount of cavernous erectile tissue. Thus it seems that the septum is made up of several thin perpendicular plates and covered by a vascular membrane. Pressure at birth, traumatism, or an abnormally high arch of the roof of the mouth are the causes usually given for malformation of the septum. There may be a deflection; the septum may be thickened, curved doubly so as to cause a sigmoid flexure or corrugated appearance, with resulting exostoses or enchondromata in the form of ridges, shelves or spurs.

I particularly wish to speak of these deformities and their results upon the upper respiratory tract, to show how much depends upon the normal condition of the septum. I will pass over with simply the mentioning such deformities as are due to ulceration with more or less destruction of the septum, and also deformities that are only noticeable externally.

Most authorities upon diseases of the nose and throat agree that the nasal septum should divide the nasal chamber into two cavities of equal dimensions. But this is rarely seen. A slight deviation is the rule.

Deformity of the septum may be caused by disease occurring directly in the structure, or as a secondary condition depending upon some constitutional lesion. Inflammatory processes involving the mucous membrane lining the cartilage may so weaken it as to permit of a slight deflection. This is seen following purulent rhinitis of children. Superficial ulceration in syphilis, tuberculosis and lupus, without perforation, may cause deflection and deformity.

By far the largest proportion of malformations of the septum are caused by traumatism. The injury may have been received in childhood but the result not discovered until later in life. Children are especially subject to injury of the nose on account of their remarkable

activity and poor judgment, and boys more frequently than girls. The injury is not usually recognized until the deflection or thickening produced by the callus which is thrown out after the fracture, obstructs nasal breathing on one or both sides. The injury may be so great as to disjoin completely the cartilaginous and bony framework.

Either from disease or more especially from injury, where the septum has been deflected, there is a proliferation of cartilage cells, usually at the sutural junction of the triangular cartilage and the vomer, which results in the thickening of the septum or growth upon it. This growth, a ridge or spur, continues to increase in size, pushing out into one or both nasal cavities until it comes in contact, or nearly so, with the turbinate body. It may not necessarily come in contact with the opposite side of the cavity before nasal obstruction results. At this stage a simple cold may, by the marked hyperæmia, bring the parts which previously have not touched, into contact and result in a constant irritation of the mucous membrane lining the nasal cavities. Thus beginning, it continues and results in a chronic inflammation. In time "permanent alteration in the tissue will result from infiltration of the submucosa by leucocytes and serum. This embryonic tissue is produced by proliferation of the migrated leucocytes and fixed connective tissue cells, which, if nutrition be adequate, goes on to organization, and the formation of a fibrinous structure which alters the nutrition of the submucosa by contraction and impairs the functional activity of the mucous glands."* The membrane is thickened and oedematous in the early stage. Hypertrophic rhinitis is of course the result.

Further contraction of the newly formed sub-mucous tissue with consequent lessening of the blood supply to the surface, and alteration of the normal function of the membrane with the shrinking of the tissues, gradually verges it from hypertrophy to atrophy. The former condition especially annoying on account of the nasal obstruction and excessive secretion of mucus which may change into muco-purulent form; the later condition especially annoying and dangerous to health on account of the fetid odor and sluggish, purulent process.

Prior to an atrophic condition, a myxomatous degeneration may take place, especially in the mucous membrane lining the dependent portion of the turbinate bodies, particularly the middle, resulting in a polypoid growth or growths. I do not say that a polypoid degeneration is necessarily due to the constant irritation of a spur or ridge. Although many theories have been advanced as to the cause of the polypus, I am sure that none is more reasonable, than that a chronic inflammatory process, kept up by whatsoever cause it may be, will result finally in polypoid degeneration, and this chronic inflammation

*Kyle, page 57.

we most often find is due to some septal deformity. This is easily demonstrated in a large majority of cases.

The symptoms indicating myxomatous growths are similar to those of chronic rhinitis, except perhaps more marked according to the extent of growths; nasal obstruction, nasal twang to the voice, worse in damp weather; discharge, the character of which depends entirely upon the extent of the growths and the length of time they have been pressing upon surrounding tissues, causing ozæna; obstructing the lachrymal duct and the opening into the antrum with antral complications.*

The myxo-fibroma and mucocoele or mucous polypus have the same symptoms and appearance as the pure myxoma and I will only mention them in passing.

From the conditions which I have so far mentioned, it is very clearly to be seen how naturally inflammation will extend into the accessory cavities, and especially the antrum. Closure of the antral opening often occurs, caused by inflammation in the nasal cavities, though by far the largest number of antral diseases are due to septic infection from decayed teeth, or to traumatism. There may be acute or chronic inflammation of the mucous membrane of the antrum or ozæna or there may be a purulent inflammation.

The ethmoid cells may be affected by direct extension of inflammation from the nasal mucous membrane or by occlusion caused by turgescence or growths within the nasal cavity. Such inflammation is easily communicated to the bony walls with consequent caries and necrosis.

Inflammatory processes of a like character, and in a like manner, may involve the frontal sinus and the sphenoidal cells by direct extension from the nasal membrane.

The following reflex neuroses may be wholly overcome, or in part, by correction of deformities of the nasal septum:

Sneezing.

Hay fever.

Asthma.

Stammering.

Stuttering.

And although chorea, epilepsy and nocturnal incontinence of urine do not strictly come within the bounds of my paper, yet I mention them in passing, as often caused by reflex irritation, from this source. If we accept the three conditions upon which the existence of hay fever depends — namely,

1st, Abnormally susceptible nerve centers.

2nd, Hyperæsthesia of the peripheral termini of the sensory nerves.

*Kyle, page 221.

3rd, The presence of one of a large variety of irritating agents,* it is easy to understand how necessary it is in the treatment of this disease to remove any local point of irritation, and thereby put the mucous membrane of the nasal cavities in as healthy condition as possible. It is a demonstrated fact that removal of septal irregularities and breaking up points of contact, has in some cases, kept the symptoms of this disease almost entirely under control.

To briefly summarize: slight deformity of the septum may, and often is, by a constant irritation to the nasal mucous membrane, a causative factor in the following pathological conditions of the nasal and accessory cavities : —

Acute and chronic rhinitis.

Hyperæsthetic rhinitis or hay fever.

Hypertrophic rhinitis.

Polypoid degeneration.

Atrophic rhinitis.

Acute and chronic inflammation, empyema, necrosis and caries of the antrum of Highmore, ethmoid cells, sphenoid cells and frontal sinuses.

The first indication of any abnormality of the septum would be nasal obstruction, and is brought about by most of the conditions above referred to. "One of the most important functions of the nose is to heat and moisten the inspired air. When for any reason this is interfered with, mouth breathing results," with the following consequences : —

Irritation of the entire respiratory tract.

Sense of smell is retarded.

Dry and parched condition of the mouth, lips and tongue.

Thickly coated tongue.

Restless sleep.

Snoring at night.

Frequent attacks of laryngitis and tonsillitis.

Hypertrophy of faucial and pharyngeal tonsils.

Expectoration of retained secretions.

Mucous membrane of larynx and pharynx dry.

Voice hoarse and with nasal twang.

In children, facial deformity.

All these morbid conditions may be relieved if we remove the exciting cause.

After thorough cocaineization which serves two purposes; 1st, to anesthetize the parts, and 2nd, to deplete the tissue, we may see clearly any deformity in the anterior nasal cavities and often see the posterior wall of the pharynx. If there be a spur, ridge, shelf or thickening, it should first be removed with the saw or knife. Such irregu-

*Bishop, page 232.

larities usually develop on the convex side of the deflection. At the same time the turbinate bodies on the other side should be carefully examined for any abnormality, which should be corrected in order that there may be room enough on that side after the septum has been straightened. After removal of such points, the tissue should be thoroughly cleansed with one of the many antiseptic washes, especially useful for the nasal mucous membrane, and the seat of such minor operations allowed to completely heal before the attempt to straighten the septum. The old method of the general surgeon in indiscriminately introducing one of the various forms of punches, and breaking down the septum, cannot be too strongly condemned. It is wholly by the careful attention to little details of the operation, and the following removal of redundant tissue that assures success.

Different forms of deflection require different methods of operative procedure.

Etherization may be necessary, but the majority of cases can best be handled under cocaine. With cocaine and the addition of a solution of supra-renal capsule to make the operation bloodless, the operator can work at the best advantage, having a reflected light and the patient in the best position, he can see clearly every step in the operation.

The bowed deflection or plain concavity on one side and convexity on the other is perhaps the simplest.

There are many methods and many modifications of the various methods. The Ash operation, which is very like the Douglas, seems to me best for the majority of cases. This consists of an incision made parallel, or nearly so, with the floor of the nose, beginning at the posterior point of deflection, passing through the centre of the concavity and bringing it forward completely through the triangular cartilage. Another incision at right angles with this passing from the upper point of deflection, through the centre to, or nearly to the floor of the nose. If there should be a marked ridge, the incision would best be made along the line of the ridge or ridges, regardless of their direction. Thus the septum is divided by several incisions, each one in turn allowing the entire septum to be pressed into perpendicular line by pressure which is made by introducing the finger, well oiled, into the nostril on the convex side. It may be necessary to use the septum forceps, the blades of which are introduced on either side the septum, and forcibly twisting by a rolling motion until the cartilaginous septum is freely movable. There is an overlapping of the edges and this should be on the free side. The fragments are held in position by hollow malleable tubes, fitted to each particular case. It often is necessary to use two, one on either side of the septum, the larger one on the obstructed side, in order to get the best position of the fragments and a union of them in such position.

The utmost care following this operation is absolutely necessary to a favorable result. A careful examination each time the splint is removed and correction of any irregularity of the uniting fragments; the thorough cleansing of the splints and the nasal cavities; wearing the splint sufficiently long, and finally the removal of redundant tissue, which is apt to follow any injury to the septum, will result in a complete and successful restoration of the normal contour and function of the nasal cavities, and may in a measure correct external deformity.

One very great advantage of the modern operation is its freedom from after pain and discomfort.

Authors referred to,

American Text Book.

Ivins.

Coakley.

Brown.

Bosworth.

New York Medical Journal, Aug. 6, 1898.

Universal Medical Annual, Vol. IV, 1895.

REPORT OF THE COMMITTEE ON GYNÆCOLOGY.

WM. F. WESSELHOEFT, M. D., Chairman,

- I. **Ventral Fixation and Suspension of the Uterus.** N. W. Emerson, M. D. Discussion opened by M. E. Mann, M. D. J. K. Warren, M. D.
- II. **Conservative Operative Treatment of Diseased Ovaries and Fallopian Tubes.** J. B. Bell, M. D. Discussion opened by E. B. Cahill, M. D. Horace Packard, M. D.
- III. **Indications for Operative Interference in Acute Inflammatory Conditions of the Uterine Adnexa,** J. W. Hayward, M. D. Discussion opened by Alonzo Boothby, M. D. G. H. Earl, M. D.

VENTRO-SUSPENSION AND VENTRO-FIXATION.

BY NATHANIEL W. EMERSON, M. D., BOSTON, MASS.

At the outset it is desired to clearly differentiate between the terms in the above title.

Until very recently they have been practically synonymous, and writers have used sometimes one and sometimes the other, to indicate the same procedure.

Heretofore employed almost in cases of uterine displacement, they have caused no end of discussion and a considerable condemnation, because of the unfortunate results. It is here intended to show that they bear a different construction, are applied to distinct processes which are undertaken for markedly different purposes, and to call attention to their application under very different conditions, and also conditions such that the usual objections have no place.

Up to the present time the difficulty has been, that after fixation of the uterus to the abdominal wall by the usually accepted methods, child-bearing was apt to be a dangerous and complicated process. Hence, during the child-bearing period it has had a questionable place, and no one could be sure in any given case that he was not storing up trouble for the future. This was, I believe, due in particular to the method most generally employed, no better presentation of which having ever been offered than that of Dr. Howard Kelley. This fixes the uterus in a condition of extreme anteversion, considerably beyond that found in the normal. The uterus is thus thrown so sharply forward that the adhesions take place to the upper portion of the posterior wall and the fundus of the uterus. This is not nature's position, and I believe eventually it will not be the accepted one when induced. When the uterus is artificially supported and fixed in this position and pregnancy follows, there is every mechanical reason for supposing that just such results will follow at time of delivery as have

been so abundantly reported. In the consideration of the class of cases to which attention will here be drawn, no objections of this kind enter, because child-bearing has ceased by reason of natural or artificial conditions already established. This leads to a distinction between the terms as well as the conditions under which the two processes are employed. By a ventral fixation is meant an actual fixation of the uterus to the abdominal wall proper, or to be more particular, to the recti muscles. By a ventral suspension, a fixation of the uterus to the peritoneum only, whereby when it finally assumes permanently its new position it is not literally in contact with the abdominal wall.

The first proposition carries with it certain limitations and its field of usefulness is therefore restricted; it should never be undertaken where pregnancy is liable to follow, and when looked at from this standpoint, it can plainly be seen that very few conditions will call for its employment, and that very possibly with a larger experience it may be restricted to cases of procidentia after the menopause. It is not necessary to review the many operations suggested for this last mentioned annoying condition, and it is hardly necessary to call attention to the quite universal failure in procuring radical relief. The very fact that vaginal hysterectomy has obtained a standing in these cases is proof that the various plastic operations, including amputation of the cervix, have largely been failures. When to this is added the fact, which I hardly think will be disputed, that vaginal hysterectomy is by no means the sure cure it was hoped it would be, one is certainly justified in seeking other means, if they are of promise. Many failures in my own experience led me to study the question anew, especially after noting the very small uterus which so frequently enters into prolapsus. Approaching the problem therefore from above rather than from below, I look upon the atrophied and functionless uterus as a means of suspending all the relaxed and redundant tissue involved in a condition of complete procidentia. The uterus is therefore fixed to the muscles of the abdominal wall itself in such a manner that it is permanently retained in contact with them and acts as a suspensory ligament. By making a small opening—(two inches will suffice) in the median line above the pubis, the fundus of the uterus is securely grasped in tenaculum forceps, brought up into this opening, and firmly secured to the recti muscles. This is done by transfixing the anterior portion of the fundus and the upper part of the anterior wall of the uterus by two silk worm gut sutures which are firmly buried in the uterus to a depth of perhaps one-half inch, and for a lateral space of from $\frac{1}{2}$ to 1 inch. The upper suture is introduced through the fundus, and the lower suture from $\frac{1}{2}$ to 1 inch away from it, on the anterior wall of the uterus.

Each one is then brought out laterally from beneath the rectus muscle on either side, passing through the muscle and all tissues anterior to it, rather more than $\frac{1}{2}$ inch from the margins of the incision. The

sutures thus lie anterior to the peritoneum. If the operation were completed without further modifications, the serious objection would still exist as it has always heretofore existed, that a loop of the intestine might be incarcerated anterior to and between the fixed uterus and the lower portion of the abdominal wall. Complications of this kind have been reported. To obviate this after the silk worm gut sutures are passed through the uterus and before they are made to transfix the abdominal wall, they are used to hold the uterus in position while the peritoneum, from the bladder and abdominal wall below the lower angle of the incision, is stitched to the anterior wall of the uterus. This is done with fine catgut, beginning in the sulcus above the bladder, and the adjacent surfaces are then whipped together by a continuous suture, which is firmly put in place from below upward until the angle of the wound is reached anteriorly and the fundus of the uterus posteriorly. All the peritoneum in this situation in front of the uterus is exceedingly lax, and lends itself to this form of manipulation without after discomfort. Care of course is taken not to embrace any of the tissues proper to the bladder itself. After this is accomplished and the silk worm gut sutures upon either side are passed through the recti muscles and abdominal wall, they are entrusted to an assistant to hold the uterus firmly in position. The peritoneum upon either side of the incision is then stitched about the body of the uterus as it is held against the recti muscles and the same suture is carried upward to close the peritoneum in the upper part of the incision. The anterior sheath of the muscles is then closed over the fundus, and the skin united in the usual way; after which the silk worm gut sutures suspending the uterus are firmly tied over a pad of gauze on either side. Usually one silk worm gut is required to close the abdominal wound above the fundus of the uterus. This constitutes a true fixation of the uterus to the abdominal wall. To one who has not seen the result of this manipulation, I am sure it will be a surprise. Instead of a wide and prolapsing vagina of very shallow depth it will be found narrow and elongated and the lax prolapsing tissues will have largely disappeared. If necessary further plastic operations may be undertaken upon and through the vagina, such as amputation of the hypertrophied cervix, and anterior and posterior colporrhaphy. In a large number of cases this will not be necessary, however, although a ruptured perineum should be radically repaired. Operations of this character would be better done at another sitting.

Ventro-suspension is applicable to a very much more extensive class of cases and variety of conditions. The operation proceeds exactly as did the former one until the two suspensory silk worm gut sutures are introduced into the uterus. Then the space between the anterior wall of the uterus and the bladder and lower abdominal wall is obliterated as described by uniting the peritoneum to the uterus by means of a continuous cat gut suture. Instead, then, of passing two silk

worm gut sutures from beneath the recti muscle, they are passed through the peritoneum, transfixing the whole abdominal wall, their relative position being the same as formerly described. Then the abdominal wound is closed exactly as in ordinary cases, the peritoneum being united anteriorly to the fundus of the uterus. After the abdomen is closed the two suspensory silk worm gut sutures are tied upon either side over a gauze pad. This brings the fundus in contact with the peritoneum instead of the recti muscles, as in the fixation process previously described. It may be well to scarify the fundus of the uterus where in contact, although this is hardly necessary since the irritation of the sutures will cause the proper adhesion. The two transfixing sutures are left in position from fifteen to eighteen days. The results in the two cases are different:—in the first the uterus is adherent to the recti muscles and held in this position; in the second it is adherent to the peritoneum, and after the sutures are withdrawn, the fundus retracts somewhat from the abdominal wall proper. This results in an elongation of the attached peritoneum, but in a manner different from suspension by the methods heretofore usually employed. Instead of having one, two or three bands of suspension we have an anterior plane of suspension which could rationally be called a third and anterior broad ligament. There follows a symmetrical support of the uterus anteriorly, which not only prevents a loop of the intestines from engaging itself in front of the uterus, but distributes the area of suspension over a considerable surface. The uterus is then held in a position somewhat analogous to a normal one. Ventro-suspension as thus applied would seem to be applicable to a considerable variety of conditions. During the child-bearing period, manipulation after this process would of course be still problematical. In one case of ventro-suspension similar to the method just described, with the exception that the third broad ligament was not created, subsequent pregnancy took place, and delivery was normal and uncomplicated at every stage. The operation permanently relieved the displacement.

Theoretically I believe that this method would not complicate subsequent pregnancy and delivery for the reason that the portions of the peritoneum affected by the operation are carried up with the enlarging uterus somewhat as in a normal pregnancy; moreover I believe that the complications already reported in cases of ventro-suspension as heretofore carried out have been due more to the condition of exaggerated ante-position than to the fact of suspension. The suspending band prevent the fundus of the uterus from being carried sufficiently high and sufficiently backward into the abdominal cavity. Distortion therefore follows. If it can be demonstrated that this procedure as here detailed is safe, where Alexander's operation has failed or is not indicated, it offers a solution of a very difficult problem. Also, if this method stands the test of experience its most extended application would be found perhaps in cases of double salpingectomy and double

tubo-ovariotomy where the normal uterus is left behind but with mutilated broad ligaments.

This class of cases by no means give satisfactory results so far as restoration of vigorous health is concerned, simply by removing the appendages. It is true that the removal of the diseased ovaries and tubes has removed conditions which may have resulted in a menace to life, if left undisturbed; but after healing has taken place following the operation, the mutilated ligaments too frequently fail to hold the uterus in position. The result is that we have a most aggravated form of displacement with all the discomforts which go with such a defect. In recent cases where both ovaries and tubes must come away, I have supplemented the ordinary operation by suspending the uterus according to the method above described. It is too soon to determine permanent results; but I am more than pleased with the encouragement thus far received.

It should be kept in mind also that by this method we have the opportunity of inspecting and removing diseased ovaries and tubes in cases of prolapsus which otherwise would be retained when plastic operations alone are employed. Thus far I have used ventro-fixation for procidentia in five cases, and ventro-suspension following the removal of tubes and ovaries in sixteen cases, and ventro suspension for retroversio uteri in nine cases, with no deaths and with most gratifying results, although sufficient time has not elapsed to draw definite conclusions as to permanent effects in the first two classes. In no case has there been unusual discomfort from the operation, and in no case has there been bladder discomfort other than the most temporary. Catheterization is always employed for several days following the operation.

DISCUSSION.

Dr. Mann: Of all uterine misplacements, the one which gives most annoyance to the physician as well as patient is prolapsus. Complete prolapsus is fortunately rare but in these cases the relaxed state of all the tissues makes help by mechanical means well nigh impossible, even after the pelvic floor is made firm by operation on the perineum.

Firmly fixing the uterus to the abdominal wall offers more hope of relief than any other operation, but, until after the menopause is passed, it is impractical in most cases. It is a question whether an operation for ventral suspension would give permanent relief, for in order to form a ligament which would hold, the adhesive bands must be very firm and strong. These uteri are enlarged and heavy and without such firm attachment would be apt to cause great pain and discomfort by dragging downward. The patient would require rest in bed for a long period while these bands were forming and also for the local treatment of the endometritis usually present, which must be relieved before any reduction of size and weight could be looked for.

In retroflexion, the other class of cases in which operation is necessary a ventral suspension would be advisable in cases where other means failed to relieve. The soft flabby condition of many retroflexed uteri is but one manifestation of a weakness and lack of tone which extends throughout the whole muscular system and relief often can be accomplished by internal medication combined with local measures.

I can report from my own knowledge but one case in which ventral fixation has been a means of permanent relief. Miss A. C., age 30, was treated locally for retroflexion for a period covering four years with varying results. At length she was operated upon by Dr. Cole of Baltimore who had been an associate of Dr. Pratt of Chicago. Two silver wire sutures were brought through the abdominal wall and secured tightly after which the wound was closed in the usual manner. A cyst was also removed from the left ovary at the time. The silver sutures were removed in two weeks. The patient was four weeks in bed and left the hospital at the end of seven and one-half weeks. The next menstrual period after the operation was delayed one week, and was painful when lying down but not when sitting up. Two weeks after leaving the hospital the cervix was slightly dilated without ether, since which time she has never had pain at menstruation, and is today a perfectly well woman.

In the cases of ventral fixation which I have seen in the dispensary, the results have been most unfortunate. The pain and discomfort far outweigh any benefit received. In the previous case, the patient was unmarried and a woman of wealth who had every care, before, during and after the operation, while the other cases were poor women who were obliged to work and thus unable to take proper care of themselves, or have it done for them.

The ideal method of retaining a misplaced uterus in position would seem to be some modification of Alexander's operation if some such method could be found. The normal uterus is not in any sense a fixed organ therefore the best operation for it would be the one which comes nearest to nature's method of holding it. For this reason the operation for suspension offers far more than that for fixation.

The local application of electricity faithfully, followed up, is often sufficient to restore to position a misplaced uterus, by giving tone and vigor to its muscle which restore it to its normal shape. This method however is of more value in versions and flexions than in prolapsus.

On the whole, the results of any operation for fixation of the uterus are so uncertain and often times productive of so much suffering, that operative measures should not be decided upon until the whole armamentarium of internal and local measures has been exhausted.

Dr. Warren: I would like to ask the author of this paper what symptoms were complained of that led him to remove the uterus in this case.

Dr. Emerson: I am sure that everybody here must be familiar with the after results of removal of tubes and ovaries. The uterus is an organ that moves backward and forward, and is without any other support, and that is the reason which led me to look for something to sustain the uterus, and sufficient time has not elapsed for me to find out what the results are. There are no specific symptoms about it. It is a condition of general incapacity. They have no symptoms. They are generally incapacitated. They are neurasthenic.

Dr. Boothby: The ventral fixation method has been familiar to us for a long time, and possibly Dr. Emerson's method is to me, but I am not sure what it is. The uterus can be fixed by a method varying a little from that, and still be what I have considered a ventral fixation method.

Now, in regard to this point which has just come up. There are reasons why the ovaries and tubes should be removed. It is frequently true that the uterus tips back, and the question of the fixation of the uterus in front depends upon the disturbances which are liable to come from pregnancy. It is not altogether desirable to have the uterus bound down in pregnancy, and yet there are a great many cases and the results comparatively favorable, when pregnancy has taken place. The woman went on to full time with comparatively little trouble, and the inconvenience was nothing in comparison with what she suffered before. The most satisfactory method is to remove the organ. If the woman is not approaching or has passed the climacteric, then the operation should not be done under ordinary circumstances. It should be only in severe cases.

Dr. Carl Crisand: Dr. Fisher has just returned from Johns Hopkins Hospital, where he has seen Dr. Kelly's work, and I am sure this Society would like to hear from him.

Dr. E. A. Fisher: I had the pleasure of seeing many of these cases operated upon by Dr. Kelly. He prefers the method of fixation rather than suspension. I saw one case which had been operated on by his method, and where the woman had been operated upon for a trouble of this kind. There had a ligament formed between the posterior side of the uterus and the abdominal wall, and there had been no severing or stretching of this. He takes two stitches of fine silk through the peritoneum and including a small portion of the posterior surface of the uterus, just behind the fundus, and leaves the silk in situ, and claims he has never had any trouble with this method.

Dr. Boothby: To what portion of the abdominal wall did he attach the uterus?

Dr. Fisher: He attached it, I should say, about $\frac{1}{4}$ inch each side of his incision. He included the peritoneum and the cellular tissue but not the abdominal wall. He did not do any scarifying.

Dr. G. F. Martin: I should like to express the pleasure I have derived from Dr. Emerson's paper. During the past year or so I have had a dozen or more of these cases, and have had satisfaction with them, not having seen any case where there has been discomfort. I want to take this opportunity to thank Dr. Emerson for his suggestion. I had a patient who was entirely incapacitated for work. I sent her to the hospital intending to do a vaginal hysterectomy, but upon getting her upon the table found the parts so congested, that I decided to open the abdomen and found the upper part of the uterus in such good condition that I decided to save it. After my operation upon the upper parts, I examined per vagina to see if further work was needed there, but the stitch upon the front and the fixation had entirely removed that, so that no further work was needed. I take no credit for this but owe it to Dr. Emerson in watching his work at the hospital. It seems to me a decided advance in cases of this kind.

Dr. Bell: It is a gratification to me to get rid of the space between the bladder and uterus. It does away with the danger of loops and bands getting in there. In cases where I have used this method I have found it very satisfactory. To my surprise I have noticed no irritation of the bladder. But we must remind ourselves that the bladder is very tolerant. We need not look for any trouble from the bladder.

Dr. Geo. R. Southwick: There is one point I have found in my experience, that, while we may perform successful ventral fixation, the pelvic floor is weak and patient may complain of dragging, unless we also restore the pelvic floor.

Dr. Emerson: Dr. Mann's criticism hardly applies here I think, because I believe the cases of ventral fixation which she has seen in the dispensary have been done by others. It is not well to make a ventral fixation in any haphazard way. I do keep these cases in bed longer than most cases. Alexander's operation I personally consider a failure. I do not think it accomplishes what it was hoped it would accomplish. The next time you see an abdominal cavity opened look and see if the ligaments are in a tense condition. If that ligament is shortened, it will most always stretch afterwards I believe. The case of ventral suspension of which I have spoken is a case that I have kept track of. When I opened the abdominal cavity I found there had been so much adhesion that the uterus was bound down. The young lady has since been married to a physician in New England,

has given birth to a child and everything went all right. If the bands of adhesions be fastened to the posterior side of the uterus (and here I take decided opposition to the position taken by Dr. Kelley) I hardly see how that can be. There is no mechanical reason why this should be necessary. We do not desire here a condition of anteversion, but incomplete anteversion. If the uterus is brought up to this point and falls somewhat backward, it is then in about the normal condition. I think the function of these bands of adhesion is to bind the anterior surface to the abdominal wall. After having done this I found that the uterus was better supported. In no single instance have I had any trouble.

To sum the whole thing up in a minute,—these cases do absolutely require an operation. If a woman has a large ovary, it must come away. These conditions occur mostly in working women, and unless they are removed, they become a burden to everybody. They must be removed. Stating it from that stand-point has led me to believe that the uterus that is supported in that way, so that it does not rest on the pelvic floor, puts the woman in a more practical working position.

Dr. Boothby: After hearing Dr. Emerson's explanation of his method I will say that I have frequently wanted to do that method, but had not the courage to do it for the first time. It seems to meet the conditions because the uterus is in contact with the bladder for some distance, and I do not see why it should not be continued a little. I do not agree with Dr. Kelley any more than Dr. Emerson does.

CONSERVATIVE OPERATIONS UPON THE TUBES AND OVARIES.

BY JAMES B. BELL, M. D., BOSTON, MASS.

Having been requested by the Chairman of this bureau to take up this subject, I will endeavor to do so to the best of my ability, but I could wish that he had set me an easier task, as the subject is beset with difficulties arising from the incompleteness of our knowledge, both as to the physiology, and pathology of these organs, and to the limits of our experience, especially on the conservative side.

While the subject might be widely discussed in all its bearings and details, I can do no more in this brief paper, than to call the attention of my colleagues to three chief points, about which all present, and future inquiry and experience will turn.

These are the *desirability* the *practicability* and the *hopefulness* of this branch of Gynæcological Surgery, or to its *importance*, *ease of execution* and *successful results*.

We may clear the field of discussion at the outset, however, by stating that the scope of these operations is as yet quite limited, and it is for this reason chiefly that experience is thus far so meager.

I am able to report only seven cases in a list of over five hundred operations of all kinds, major and minor, hospital and private, in my own experience of the last four years, since I began to make these operations, and I have been able to find in the literature, reports of only the following list of cases:

Eighty by Dr. W. M. Polk, 45 by A. Martin, 7 by a number of operators, all quoted in Kelley's *Operative Gynecology*, (Kelley does not give the number of his own cases but evidently draws upon quite a full experience) also 22 cases reported by Dr. Donnet and operated upon by Pozzi, although Pozzi himself does not once refer to the subject in his great work on *Gynecology*.

I may say that this report of Donnet's was the first of my reading to arouse my courage and hope in this direction, and to justify me in my own mind in this somewhat experimental proceeding. I was also aided in it by an intelligent and very determined young lady who would have this operation done, and absolutely nothing else, and whose case I will report later.

I may also remark that since studying Kelley's article upon this subject in his admirable work, which I confess I had not done before I began this paper, I feel quite inclined to the conviction that the limits of these operations may be considerably extended. We may be able to consider this part of the question later.

First: As to the desirability and importance of conserving the ovaries and tubes, I may best quote directly from Kelley.

The reasons for conservatism are :

1. "That it is the general attitude of all true surgery.
2. The important uses and relation of the conserved structures to the human organism.
3. The recognition that what were once considered diseases of the tubes and ovaries are, in many instances, no disease at all.
4. The recognition that a disease of part of a structure, ovary, tube, or uterus may only demand the removal of that portion which is diseased.
5. The discovery that in certain diseases an entire regeneration may take place and badly diseased tubes may again become normal in their functions.
6. On account of the value of the structures involved, ovary and tube are no longer removed *en masse* for purely technical reasons, but a diseased tube or part of a tube, a diseased ovary or part of an ovary, are removed by themselves, each without interfering with the other.

1. Conservatism the highest aim of surgery.

It is almost an aphorism, in general surgery, that exsective surgery is its opprobrium, and no conscientious surgeon removes a limb or part of the body which could be restored to its usefulness, by a careful conservative treatment. I shall never forget the impression made upon me, as a hospital resident in 1882, when I saw a boy brought in with a clean, compound fracture of one forearm, and simple fracture of the radius, ulna, and humerus of the other arm, and the surgeon amputated both arms.

If the traditions of surgery and its best principles all point toward conservatism as its highest goal, there is no reason for making any exceptions to these rules in the special field of gynecological surgery.

2. The importance of the conserved structures to the welfare of the patient.

The pelvic organs are indelibly associated in a woman's mind with those fundamental differences between the sexes which impress upon the female organism all that is distinctive and peculiar in her attitude toward the world at large; and with the healthy performance of her functions in the recurring monthly fluxes, ovulation, and the possibility of conception, lie, though the woman may be unconscious of it, some of the deepest wellsprings of her happiness.

The effect of the removal of the sexual organs in woman is, in many instances, entirely analogous to the corresponding operation upon a man, disturbing her psychical and physical balance, and bringing on a state of wretched confusion in the new and anomalous relationship in which she finds herself.

Ovulation and pregnancy under suitable conditions are, to a degree utterly unappreciable to the male mind, essential elements of woman's happiness. To dwell upon this point would be but to reiterate what any attentive surgeon may gather from his daily experience in the consulting room, and to rehearse well-known facts in the history of womankind.

Internal secretion. There is a growing conviction that the ovary belongs to the same group of organs as the thyroid, thymus, and pineal glands, and that, in addition to its function of ovulation, it secretes a substance which is absorbed and consumed in the animal economy, and which is necessary to it in retaining its physiological balance."

I think we may well guard these statements, however, by saying that we now have no morbid or extreme notions about "unsexing of women" or anything that approaches it, by a necessary removal of any or all the pelvic generative organs. No man or woman is unsexed in general physique or character, by the removal of ovaries or testicles after maturity. No woman becomes less a wife, or less feminine; no hair grows upon the face; the form and bearing do not change; the voice retains its sweetness. I have in mind at this moment, a lovely young woman from whom seven years ago I removed both

ovaries for one large and one small cystoma. She is a professional singer in church and concert and has never sung better than now. Only last year she had a most acceptable season in London, and has lost nothing of any grace of form or feature.

It is such cases as these of which my colleagues with myself could produce a great many, that leads me to doubt somewhat the ovarian secretion theory.

I have also found the discomforts of the meno-pause when induced by operations, to yield as readily to the carefully selected Homœopathic remedies, as when occurring physiologically. Lach. Sang. Sul. ac. Sul. and other remedies have given most excellent results.

The possibility of child bearing appeals to us quite as strongly as any other consideration in favor of conservatism, and there are reports of cases which show that pregnancy has occurred under most unlikely conditions. Kelley reports one case of pregnancy, followed by the birth of a living child, after removal of the left tube and right ovary. Dr. Winn reported a case that he opened for obscure conditions after two ovariectomies by other surgeons, and found a pregnant uterus with a stump of a tube on one side and a small bit of an ovary on the other.

The fact that, of all the cases cited in this paper, there is a record of only twenty-one pregnancies after the operation, is accounted for by the facts that many of the patients were and remained unmarried, that there were other conditions causing sterility, and that in many cases gonorrhœa or other abnormalities had rendered the husband sterile, and in other cases still, there may have been intentional prevention; of this I am quite sure in one case, and entirely so in another.

Kelley's sixth head, "on account of the value of the structures involved, ovary and tube are no longer removed *en masse* for purely technical reasons, but a diseased tube or part of a tube, a diseased ovary or part of an ovary are removed by themselves, without interfering with the other," brings us to the consideration of the indications for conservative operations, as opposed to radical ones.

The clinical indications are pain, suffering and ill-health sufficient to warrant an examination under anæsthesia if necessary, confirming the diagnosis of radical changes in the ovaries or tubes, sufficient to justify a laparotomy.

A severe and intractable dysmenorrhœa, the pains beginning several days before the flow, with much tenderness of the breasts for days before; the examination revealing enlarged and cystic ovaries with perhaps partial or entire prolapse of one or both of them, is a typical case for this sort of interference.

While it may have been justifiable formerly in such a case, to remove the tubes and ovaries and bring about the meno-pause, it is by no means so now with our present light and experience. The same

is true of any other pathological condition in the pelvis that can be corrected without the removal of these organs in their entirety.

One leading consideration now justifying us in making attempts at saving these organs, is the greatly increased safety of these simple laparotomies, and thus the practically greatly increased accessibility of these parts.

When, as formerly, a simple opening of the abdomen meant a death rate of over 5% we were certainly only justified in doing most radical and permanent work, but now that with the present improved asepsis technique and personal experience we can count on almost no mortality at all in these simple cases, we may indeed feel it right and proper to make an operation which promises such great results even though some cases may require a second opening of the abdomen, occurrence that is not so very rare in other conditions.

Next, as to the *practicability* of the conservative operations which also includes the technique. To go into this in detail would take too much time. The operations are easy and simple for the most part, only requiring that surgical sense of the fit and proper thing to do as in all other surgery. The cystic ovaries are resected if practical, leaving the sound portion which is more often at the hilum, and closing the wound with buried and continuous fine catgut suture, or individual cysts are opened and thoroughly curetted and left open. Pozzi's method is puncture and cauterization of individual cysts with the thermo-cautery. I followed this at first but it is not as neat and truly surgical as the knife.

Adhesions and distortions of the tubes are loosed and straightened out, the tubes made patulous, all other adhesions loosened up and any hopelessly diseased structures removed.

The power of restoration of these tissues thus aided is well shown in the following case reported by Dr. Burrows :

"A patient was operated upon and a purulent tube and ovary were removed from the right side; adhesions about the left tube and ovary were broken up, the closed end of the tube was opened, and the cystic ovary was resected, about one-third of it being removed. On opening the abdomen a year later to cure a ventral hernia, the tube and ovary were found free from adhesions and perfectly healthy, the fimbriated extremity was open, and no evidences of the ovarian resection could be found; the health of the patient was perfect except for the hernia."

The case just cited may well introduce our last division, the *hopefulness* of these operations:

In Polk's eighty cases he reports that all but seven gave excellent results after from six months to two year's observation. Martin does not give the details of results but they were evidently favorable on the whole. Pozzi's twenty-two cases gave thirteen perfect cures, six greatly improved, and three failures. He has made the operation

about sixty times without a death, but has not yet reported the more recent cases.

My own seven cases I will now briefly detail. My limited experience would not, alone, entitle me to speak on this subject, except, perhaps, from the consideration that we may often learn much from a few cases.

Such as they are I think they all tend to establish the three main points in this paper, except the last two in which sufficient time has not elapsed for a proper test of the results of the operations.

Case 1. Miss S., age 18. Increasing and severe dysmenorrhœa so severe as to cause symptoms resembling Hystero-epilepsy, only controlled by the abundant use of ether, to which she was becoming addicted. Catamenia began only a year ago. Had to be etherized for only an hour at first, now three to five days. Has used at one time five and a half pounds of ether, without it, has convulsions of the nature of Hystero-epilepsy.

Operation May 7, 1896. One large cyst and eight small ones in left ovary all cauterized and ovary loosened from some adhesions. Right ovary, eight small cysts punctured and cauterized with thermo-cautery.

The next two periods very comfortable. No ether required. After she left the hospital her history has been somewhat fluctuating. Was married about two years ago and has had two pregnancies, both miscarrying, the last with a placenta previa, but on the whole her health is good and she has greatly improved in strength and vigor.

Case 2. Miss L., age 24. History of painful menstruation, and symptoms of pelvic irritation. May 6, 1896, examination under ether; enlarged left ovary, right ovary prolapsed behind the cervix.

May 12, 1896. Pozzi's operation. One large cyst on left ovary curetted and cauterized. Right ovary slightly cystic. Several small cysts punctured and cauterized. Have found it difficult to get this patient to report but have learned indirectly that she seems to be well.

Case 3. Mrs. H., patient of Dr. Kennedy of West Medford. Age, 35. Married five years. Never pregnant. Frequent and protracted menstruation for several months. Has always had much pain, more on the left side.

May 26, 1896. Left ovary and tube adherent, ovary cystic, tube and ovary removed. Right ovary enlarged and cystic. Eleven cysts punctured with cautery.

Improvement begun soon after the operation and has continued with some alternations. Dr. Kennedy writes me Sept. 18, 1899, "I am pleased to state that she is free from the symptoms which called for her operation."

Case 4. Mrs. O., age 30. Married seven years. Has one child four years old. For one year irregular menstruation and severe pain

in both ovarian regions. Much and almost continuous flowing the last few months. Examination under ether. A large mass on the left side filling the pelvis, rather firm and irregular.

Operation May 22, 1896. Large hæmato-salpinx on left side with diseased ovary, removed; right ovary cystic, eleven punctures with Paquelin cautery. Gradually improved in health, and except a possible abortion at one month a year and a half ago, is perfectly well, doing her own work and taking care of a sick husband. Her own words a few days ago are, "My operation was a perfect success."

Case 5. Miss G., a Swede. Had a child born three weeks ago. Operation June 1896. Large ovarian cyst left side removed. Right ovary enlarged and cystic, three cysts cauterized.

Patient left the hospital well, but have been unable to trace her since. She had had no history of ill-health.

Case 6.. Miss P., age 23. Menstruation never regular, often late, but backache and headache all the time. Much pain during catamenia. Constant ovarian pain on both sides, more on the left. Examination retro-version. Left ovary prolapsed and cystic. Right side the same in a less degree.

Operation May 8, 1899. One cyst in left ovary as large as a walnut. One half of ovary excised in a long wedge shape. Right ovary generally cystic, excised in the same way. Made a ventral suspension, following Dr. Emerson's method.

The patient was much better before she left the hospital, but I have heard from her since and she does not seem to be improving.

Case 7. Mrs. M., age 30. Has had four pregnancies, one laceration of cervix repaired five years ago. Youngest child two years old. Menses irregular coming every two weeks for the last two months. More or less continued pain in left ovarian region extending down the hip. Very sensitive on that side, constant headache.

Operation May 3, 1899. Right ovary, large cyst excised and wound close with cat gut. Two small cysts punctured and curetted. Left ovary, five small cysts punctured and curetted. Uterus inclined to retro-version. Ventral suspension, Emerson's method. The tubes seemed normal. She writes me Oct. 3, "I have not been so well especially the last four weeks; am better in many ways than before my operation." Has "been obliged to work quite hard," and had a hemorrhage five weeks ago.

NOTE.

Since presenting this paper, Dr. Southwick has kindly called my attention to two important articles on the same subject, published by Dr. A. Palmer Dudley in the *American Gynecological and Obstetrical Journal* and which had escaped my notice.

Dr. Dudley reports in all ninety cases, but does not give any full report of the results, probably from the difficulty we all meet with in

following up cases after they leave the hospital. In those cases in which he does give the after results, they are most favorable. There seems to have been no mortality, although quite a number of pus tube cases were included in the list of operations, and these seem to have done quite as well as any. He reports ten pregnancies as resulting, and thinks there have been many more.

DISCUSSION.

Dr. Cahill: I stand before you believing very firmly in conservative surgery. I would like to cite three cases. These cases came to me as they frequently do to the general practitioner, for the great suffering. They had been treated by many physicians but with little or no relief. Mrs. T., operated on by Dr. Boothby four years ago. Left ovary enlarged and tube diseased, and some endometritis also. Left tube removed and ovary and uterus corrected. Anterior fixation not made. Married woman and anxious to have a family. I felt very strongly and Dr. Boothby believed as I did, that anterior fixation should not be made. The other ovary was some diseased, but the cysts were punctured and curretted. She made a very good recovery as far as this was concerned, but a very poor recovery as far as her general condition was concerned. She was melancholy and her family felt that the conservative method was a mistake. Nine months after she came to me and was not any better. Was a little stouter but her general condition was deplorable. She wanted my opinion about going to Dr. Boothby and having the other ovary and tube removed. We waited another year and she was a little better. She had cod liver oil, and had travelled, and felt some brighter and better. The instrument was taken out and the uterus fell back. She came to me later and was pregnant. Was delivered of a healthy child, and today is a well woman. Now, that was an example of conservative surgery.

The second case was a Miss C. Operated upon three years ago by Dr. Emerson. She was operated on, and found the ovaries cystic. Dr. Emerson tried by puncturing the cysts, to leave some healthy tissue, but there was no healthy tissue there. Both ovaries were removed. That girl has experienced all the symptoms of the menopause. She suffered to the full extent. Nothing seemed to help her. Three years passed by and today she is quite well. There is another case of conservative surgery, I thoroughly believe.

Case No. 3 was a Miss G. Operated upon by Dr. Packard. One ovary and tube removed. She was very neurasthenic. She went on for a year, gained quite a little flesh, but was far from well. A year ago she went South, and it was urged upon her to remove the other tube and ovary.

Now, if a woman has been sick and neurasthenic for quite a long time, if she has considerable disease in tubes and ovaries, it is a great

question with me in my practice if she is any better after the removal of these. I do not know any better course than to advise the removal, hoping that after the original cause is removed the woman may gain. Yet, it is a question with me if she is cured. I am becoming more and more conservative about removing. I want to do more for these cases. I do believe that the mental impression does make a vast difference. Now with that young lady three years ago. One tube and one ovary was perfectly normal. Now I believe if I had told her "This other tissue I do not think you will ever have any trouble with that," she may never have had any trouble. She went on from bad to worse. I yielded to what was perhaps cowardice but what I believed to be right, and she was operated upon. Today she is no better. We live in a day of psychical development. Sick people are very impressionable. It is a question just how much to tell our patients. If the woman is not too far advanced in neurasthenia, so as to be unbalanced, my experience has been very favorable with conservative treatment.

Dr. Boothby: Mr. Chairman, the matter has been well discussed, and I believe what has been said. I believe in conservative surgery, even when it is not altogether successful. I feel that some of the cases that we do feel compelled to operate upon, are more often subjects for a neurologist than for the surgeon. However, good is done by conservative surgery.

Dr. E. P. Colby: I have not had such a great deal of opportunity observation, but what little I have had leads me to think that when these cases fall into the hands of the surgeon they have already established the neurasthenic habit, and no operation nor anything of the kind is liable to produce a cure. Suggestion has as much to do with it as anything. If there be a badly diseased ovary which you are sure is causing inflammation, then it is good practice to remove the cause, hoping that some good will come, but as I said before the case has gone on to such a degree that you cannot expect to cure from any such procedure.

Again, I feel that there are a large number of cases of diseased ovaries and diseased uteri that the surgeon knows nothing about. They are selected cases which come to us, but back of all cases there is an irritable nervous system, or a weakened condition that makes them suffer, and that ought to be taken into consideration. If all cases could be selected, taking only those cases which are not of that peculiar type, then I do feel that we would have better results than surgeons turn over to us. I have seen everything as after results, developing after it, as I have seen after operation, consequently, I am very much on the fence.

Dr. Stone: Dr. Colby has just cited a class of cases which trouble me greatly. One case comes to me which will perhaps confirm his idea. This woman had a lacerated cervix and perineum, and was operated upon. Two years later she was just as bad as ever. After consultation we took out both ovaries. Two years later she is no better, and about six months ago she was in Westboro with what the doctor called there, appendicitis. She was sent home, and forty-eight hours after I saw her, and I could see nothing of appendicitis. She was all right and back just where she was. I think that is the class of cases where you operate from beginning to end and feel just about as well satisfied after the operations as before. The last three weeks she has made more progress. Rides out on her bicycle, and I believe getting out and having exercise will do more for her than the operations, yet, I would not say that the operations were not called for. The ovaries were diseased and there were cysts in them, but after operation there was seemingly no substantial recovery.

Dr. Emerson: I want to cite a case of a young woman unmarried. Ovary and tube was removed on one side, and portion of the other. Shortly after leaving the hospital, was married, and in about a year came to me much dragged out and very pale. She had had a miscarriage from an accident at Jordan Marsh & Co's. There was a perfectly healthy fetus of five months.

Dr. Bell: It is perhaps one, two or three years before patients get the benefit of these operations. I just wanted to make that point clear, that is all.

THE SURGICAL TREATMENT OF ACUTE INFLAMMATION OF THE UTERINE ADNEXA.

BY J. W. HAYWARD, M. D., TAUNTON, MASS.

It is the object of this paper to evoke discussion, hoping thereby to draw from the members of this Society results of their experience and observation.

Thus far there has been—to my knowledge—no established rule for the surgical treatment of acute inflammations of the uterine adnexa. Each physician has therefore been left to work out the salvation or destruction of such patients as may have fallen into his or her hands for treatment, and by the consensus of results, it is hoped to formulate something which may be of general utility, and great value to our fellow-women, who already have more than their share of inconvenience and suffering.

That we may take an intelligent view of the subject, we must first understand what we mean by adnexa; what are their normal functions, and what are likely to be the results of inflammation thereof?

Literally adnexa means that which is joined to the womb; practically it has extended to embrace the whole pelvic sexual apparatus. For the convenience of this paper I shall confine the term to its literal meaning (the Fallopian tubes) and the other parts of the sexual apparatus come in, only as they are drawn in, by inflammation of these tubes. All inflammations must have an acute stage, and the question before us is—How shall we deal with acute *tubal* inflammations? There are two objects in the treatment of all organic diseases—a primary and a secondary. The primary is to restore the organ to its normal function. The secondary is to prevent the disease from extending and involving other tissues and other organs. Especially is this true in the disease under consideration.

The Fallopian tube is merely a duct. Its normal office is to convey the matured ovum from the ovary to the uterus. Both ends are patent; one opens into the uterus, the other into the pelvic cavity. The pelvic end under certain conditions grasps the ovary to suck out the matured ovum and convey it to the uterus. This office performed, it appears to relinquish its grasp upon the ovary and remains quiescent, with its free end opening directly into the pelvic cavity.

An acute inflammation shows the presence of a propagating germ, and means extension, unless restricted by force or enticed away by an easier or more attractive route. The strepto or gono-coccus enters the uterine end of the Fallopian tube. He speedily kindles his fire and moves rapidly towards the free or fimbriated end. His retreat is speedily cut off by the swelling and agglutination of the lumen of the tube at its uterine end; and fortunate is the victim if the mischief going on inside the tube, excites sufficient contraction to draw the fimbriæ together and thus imprison the mischief-making germs for the pyo—or later the hydro—salpinx will make the surgeon's duty clear to him—without having seriously endangered the patient's life.

But suppose the free end is not sufficiently closed—or that the fimbriæ grasp the ovary; what is then the result? In one case the warring microbes rush in through the open door and assail the pelvic organs, setting up a general pelvic peritonitis or a suppurative process, and pelvic abscess. In the other they burrow into the ovary itself and induce an ovarian abscess.

One condition is as grave as a thing well can be, and the other is serious enough. The man does not live who has been once through with a case of suppurative pelvic peritonitis, who would not do almost anything to prevent it; and when we think of the serious consequences to the female life, of the loss of an ovary—to say nothing of the immediate danger from the ovarian abscess, we can but feel that we are justified in taking early radical measures to arrest the inflammatory process while it is absolutely confined to the Fallopian tubes. Why then would it not be good surgery to curette and disinfect the womb, ligate and remove the inflamed tube, and leave an open drainage route for the pent up microbes to escape?

The conservative may object on the ground that such procedure in early life would induce sterility. In reply I will say the disease will do that, besides greatly increasing the dangers to life and almost absolutely insuring the destruction of the ovary. We cannot place too high an estimate upon the value of the ovaries, even if the tubes and womb are gone. I believe the ovaries have a very important part to play long after they cease to be a medium of propagation.

In addition to their generative function they secrete a vital fluid. Similar to that secreted by the thyroid and while it may not be essential to life it is essential to the proper balance of the physical and psychical life of woman.

DISCUSSION.

Dr. Boothby: In the first part of the paper I might criticise a few points in pathology but that is not what I am here for. The matter of surgery, the acute inflammations of the adnexa, and Dr. Hayward limits us to the tubes, and he asks the question, why not curette the uterus. Well, that does not quite get at the disease, that would be the only objection I would make to that. Now, inflammation has travelled up the tube, and if you remove the inflammation from the uterus you have not cured the inflammation in the tubes by any means. In some cases it has been satisfactory, but in a large number of cases it has not. In inflammation we need not necessarily get any pus. If we get no pus formation I am not at all sure that the surgeon comes in at this stage. I should say that it was a case for treatment. As it was brought out this morning in discussion of a similar subject, the inflamed tube may be treated and become normal, and that we should look for. It would depend I believe on the kind of inflammation. The streptococci do not get up there. Still, other kinds do get up there of less virulence than have been mentioned. Now, suppose the case has not yielded to treatment other than surgery. Supposing that it has not yielded but has gone on. Then we suspect pus or gonorrhœal infection. And yet there is not pus formation. It is that partially organized material in the tube that we find so frequently that produces the disturbance. If pus has formed, then we certainly ought to let it out, and if it be confined to the tube, and you can get the fluctuation from the vagina, the operation would be to open the tube from the vagina.

In the old cases where it has lasted for a long time, we are to consider whether the abdominal route is not preferable. We do know that the streptococci do pass through the tissue, that they will penetrate the tube and pass out through the peritoneal cavity. In these cases possibly the connective tissue is also affected, and we might make incisions in the tissue to relieve the pressure, and you would resort to that in some cases. In these cases of virulent poison, we gain very little by curetting the uterus, in my opinion, unless you do it very early in the disease. If I had a severe case at the present time, I think I should consider very seriously if an incision into the abdominal cavity, allowing an escape of the matter, might not be beneficial?

Dr. Southwick: In regard to the conservative treatment of these cases, I would like to say, that by extended treatment I know they recover. I have seen such instances repeatedly. If you operate on these cases there is increased risk of infecting the peritoneum. Later on we can operate, if the case does not get better, and we can operate under conditions where there is less danger of infection. I really think, in the interests of mankind, that woman is entitled to a second operation. Use conservative method first, operation afterward. I would plead most earnestly for the use of remedies to cure the acute condition if possible. There are cases, of course, where there is pus,—but that is another matter.

Dr. Rand: There are two points which I had hoped would be cleared up. I hoped that some one would give us some points on catheterization of the Fallopian tube. The other point is that these cases do finally come to operation. Many do not come to operation,—others do. Two cases have come under my observation. I called Dr. Coffin's attention one day to a patient who was showing every symptom that both tubes were affected. I never had a chance to tell Dr. Coffin that later I had Dr. Packard see the patient. She was not operated upon and made a complete recovery.

Another case following septic infection from gonorrhœa, in which there seemed to be every indication through the vaginal orifice, and that made an uneventful recovery after some weeks, and I have heard nothing since.

Dr. Hayward: In regard to what Dr. Boothby has said, and in justice to him and to myself, I will say that that part of the paper about the ovary was left out, through a mistake of the typewriter. Further, I do not think Dr. Boothby quite comprehended my paper. I said why not curette the wound, disinfect it, and ligate the tube? The Doctor seemed to separate the two. I can recall the time when everybody said, do not operate upon an inflamed appendix in its inflammatory stage, but wait for suppuration and the day when you are obliged to operate. Now-a-days, most surgeons take it within 48 hours, I think the results show that there is less danger at that time than at any other time during the disease. Those cases start simply as an inflammation. They go on in most cases to suppuration, and by the time you have a pyosalpinx, you have other tissues involved, and when you do operate you are obliged to do a much more extensive operation than you expected.

I believe the ovary is something that should be left. You may remove every other part if you leave the ovary. The office of propagation is only secondary, I believe. There is more to it than that. I have seen some cases where the pain was so bad that the patient could not bear it. I believe that we should try every other means before removing the ovary. With regard to the catheterization of the tubes, I have had no experience. Neither have I any faith in the relief that you would get from that source.

**REPORT OF THE COMMITTEE ON DERMATOLOGY, SYPH-
ILOLOGY, AND GENITO-URINARY DISEASES.**

S. H. BLODGETT, M. D., *Chairman.*

I. Gonorrhœa, Clinical Suggestions. Orren B. Sanders, M. D.

II. Prevention of Baldness. John L. Coffin, M. D.

GONORRHOEA — CLINICAL SUGGESTIONS.

BY ORREN B. SANDERS, M. D., BOSTON, MASS.

True Gonorrhœa has but one mode of origin, namely, contact of a discharge containing the gonococcus of Neisser with a mucous membrane. It is not necessary that an abrasion of the mucous tissue should exist.

When the urethra has been damaged by former urethral disease, a purulent discharge may be caused, resembling closely gonorrhœal discharge, but free from any gonococci, therefore not specific. This condition, as is well known, can be, and frequently is, produced by excessive coitus, excessive indulgence in alcoholic stimulants, etc.

Such a damaged urethra may be thrown into such an inflamed condition as to closely resemble a specific condition, by contact with leucorrhœal, lochial, or menstrual discharges, passage of calculi, acid urine and the like. This condition occurs so frequently, and many times so closely resembles true gonorrhœal urethritis that many mistakes in diagnosis have been made, incurring a vast amount of misfortune upon innocent men and women. While it is important that a true understanding should be had concerning real gonorrhœa, so we claim that it is far more imperative that cases of non-gonorrhœal discharge should be more carefully diagnosed. In all cases great care must be used and conclusions must not be jumped at in diagnosing the various urethral discharges. In all cases it will be far wiser to look with the microscope for gonococci and even more than once, before any doubtful case is decided upon.

You will note that we say a urethral discharge can be established in a urethra by various indulgences, as excessive coitus, stimulants, etc., but remember only in a previously damaged urethra, or, in other words, where the man or woman has had a previous gonorrhœa or else had some mechanical injury to the urethra, for we firmly believe and from all our clinical experience have verified it, that a perfectly healthy urethra, free from any previous gonorrhœa or other mechanical injury, I repeat, a perfectly healthy urethra, (previously uncontaminated) can withstand any and every contact with menstrual,

lochial, or leucorrhœal discharge, excessive coitus, and alcoholic stimulants, and come out of such contamination unblemished; therefore we affirm that when a urethra shows any unhealthy evidence, or any discharge from excessive coitus, or contact with menstrual, lochial or leucorrhœal discharge, or from acid urine, etc., then we claim that one of two things has happened: Either that he has a specific gonorrhœa from that contact, that the woman has a gonorrhœa about her from which he has contracted it, or else the man has had his urethra previously damaged, either by gonorrhœa or mechanical means. We admit many cases will present themselves about which at first, there is a halo of uncertainty, still on proper further investigation you will invariably prove the assertion, as above made, correct.

Having made these preceding statements, which we believe to be absolutely correct, how is the great danger, and how is the immense amount of after results of a damaged urethra to be overcome?

For numberless reasons, very few men of the vast number who have an acute severe gonorrhœa, ever absolutely recover without having left either a stricture of at least, large calibre, or else some small portion of the urethral mucous membrane damaged. As I have just said, for numberless reasons. One is that so much impatience is always present for quick recovery that the patient himself is to blame for not following out the proper treatment long enough; another, because his physician is not conversant enough to intelligently treat the patient, and such are legion; another, because of some idiosyncrasy in the patient's general constitution, as is the case in many other diseases, also the virulence of that specific germ is such as to create great havoc in spite of the very best treatment, and, last but not least, the patient's carelessness in carrying out all the necessary hygienic caution, so necessary in this disease.

These are some of the reasons why so many sequellæ remain from gonorrhœa. There are a number of physicians, well read and educated fellows, too, who claim a gonorrhœa is no more to be dreaded than an ordinary cold or coryza, but I fear their observation is limited, or else they do not follow closely enough the condition after treatment, as it is really essential that the case should be under observation for at least six months before it is possible to verify a positive cure. In addition, it is so easy for a man to overlook a little moisture from the urethra, or a small, so-called milinary drop, mornings, or some amount of dribbling at end of urination, all of which symptoms are, at least, suspicious of a latent disease sure to develop later into mischief, both to himself and more particularly to any woman with whom he may cohabit.

Now, this brings us to the very point for which this paper is written — to unravel if possible, in a feeble way, one at least, of the reasons why so many women suffer from gonorrhœa unknown to themselves, until some physician called to her discovers a well ad-

vanced salpingitis, or ovarian disease, many times so far extended that nothing short of total extirpation will relieve her, the starting origin of which can surely be traced to gonorrhœal contamination. It is wholly unwarrantable and far from the truth, to contribute all the contagion produced in women to a conscious exposure to the virus, either by the man or woman. In fact we believe that cases produced in women are by far in the minority where there has been a conscious exposure by either the man or woman, therefore in our opinion it narrows down to the bare fact that the great majority of women who contract gonorrhœa are unaware of it, or even of its presence after contraction, and in addition, we believe that the man or husband who gives the virus is unaware of the blemish he has placed upon her. This being true, how then can it be accounted for?

You, no doubt, have already understood by the preceding thoughts what we consider the great danger and at what stage the greater part of all contamination in gonorrhœa, and at what stage it is propagated and spread through the world. It is at the stage of decline and the period following, when a damaged urethra remains either with or without stricture, where gonococci are present but so dormant that so little evidence remains, that the man considers, and most always honestly so, that he is now a cured man, able to continue the sexual relation without either harm to himself or to the woman with whom he cohabits.

Granting this theory to be true, while in a few cases the man disobeys his medical adviser, takes upon himself his own diagnosis and prognosis in spite of the most careful warning of his physician as to the probable, or at least, possible harmful consequences, yet we believe in the great majority of the cases, the physician is wholly to blame, and for two reasons: First, because he, being careless or else not thoroughly a believer in the far reaching effects of the disease, does not intelligently instruct the patient as to his exact condition, both present and future. Secondly, because he himself is not competent in that branch of medicine to intelligently instruct him.

It has been considered in the past years that gonorrhœa amounted to but little and could be easily cured, and medical men were loath to devote much time to the study of gonorrhœa or its consequences, almost considered it as being beneath the dignity of their reputation, and if a man did devote any spare thought or attention to this malady, he would be known by the familiar sobriquet "Clap Doctor." The reason, that a large percentage of women become gonorrhœic after marriage is because the majority of men become gonorrhœic usually before marriage, and a large percentage of these remain in an uncured or latent stage for a long time. In addition to this, we consider the importance of this question, as we read the statement that Noggerath thinks 70%, while Sunger conservatively places it at $\frac{1}{3}$ of all the diseases.

of women which the Gynæcologist is called upon to treat are caused by the sequellæ or unsuspected latent gonorrhœa of the man.

From close study and observation of many cases, we believe that many men and women are today the unconscious carriers and transmitters of gonorrhœa. This is peculiarly so because whenever a gonorrhœa is produced from gonococci of a chronic gonorrhœa, or a latent gonorrhœa, thrown into activity by some peculiar excitement, the disease is apt to be mild, thus accounting for so many women unsuspectingly being contaminated and not knowing they bear the diseased germs and so unconsciously carrying forward the contagion to others.

From the preceding remarks we draw the following conclusions:

1. A vast majority of men who contract gonorrhœa never fully recover, either carrying a damaged urethra, a stricture of large calibre, or else some latent gonococci.
2. Owing to this fact, many women are diseased, unconsciously to themselves, or to the man who conveys the germ.
3. This condition of things in a great measure can be laid upon the physicians who treat the cases, because of their carelessness in not properly instructing the patient, or their inability to properly treat the patient.
4. Every precaution should be taken by physicians who treat gonorrhœa to use every device known to the scientific physician to determine the correct prognosis by use of microscope, endoscope, etc.

DISCUSSION.

Dr. Krauss: Yesterday morning I received a telephone message from my friend Dr. Sanders, asking me to say that he was a good fellow. I am here to call him a good fellow because I do not take any exception to what he has said. I believe that the diagnosis of gonorrhœa should not be jumped at. I believe with him that a damaged urethra can easily become inflamed, but I do not agree with him that these patients do not recover if they have a damaged urethra. gonorrhœa is more to be dreaded than a cold, and I want to raise my voice against this term, "Latent Gonorrhœa:" I consider this term a misnomer. There is gonorrhœa or there is no gonorrhœa. Latent gonorrhœa is a term that is incorrect on all sides. If gonorrhœa infects a person it cannot be a latent gonorrhœa, it must be an active gonorrhœa. Long after it has invaded the deeper structures, gone into the bladder, the serous membranes of the joints, or effects the meninges, we may not get a urethral discharge, but we obtain something by which we have a criterion, by which we can tell the patient whether he has gonorrhœa or not. He has a chronic condition of gonorrhœa, not latent gonorrhœa.

Dr. Hayward: Mr. Chairman, my opportunities of observing in that direction have not been very large, but I believe that as except it refers to the Fallopian tubes and the uterine adnexa, that a large percentage of cases of inflammation of the uterus and of the Fallopian tubes is due to gonorrhœa, but not as large a percentage as we have been taught to believe. I think it is rather an unusual thing for a tube to become a pyosalpinx as a result of gonorrhœa. I think we get a thickening of the tube from that cause, and an extension of the disease to the pelvic tissues. That is only one of the results. I think there is another one, that the gonococcus works its way up the ureters to the kidney. While I believe in conservative surgery, I still believe what I said in my paper, that a tube had better be removed in early stages of inflammation than left until it goes on to extension to other parts. I think quite a percentage of cases of gonorrhœa in the female do extend to the Fallopian tubes, and quite a percentage of inflammations are due to it.

Dr. Sanders: I am not taking any particular class of the population into consideration when I estimate the percentage of people who have suffered from gonorrhœa, in all classes, poor, middle and upper classes. I will still say that 50% have had gonorrhœa.

Now, on the other point, I do not care whether you call it latent or chronic gonorrhœa. The fact that I wish to bring out is this: that there are so many who are not cured. They remain in an uncured condition. Why? Because men are not able to tell when there is anything the matter with the urethra. For instance, a man who graduated from Boston University a few years ago, was examined by a graduate of the previous year. Gonococci were found in the discharge, and for three years the condition had been going on. You and I know how many men and women have been affected by gonorrhœa. I claim that when a man presents himself to us with gonorrhœa we have no right to prescribe for him a remedy, and send him away saying, "You are cured." That is wrong! It is criminal! We should follow them up; then, and only then, will we know whether they are cured or uncured. I am sure you would be greatly surprised to know how many men you will find have not been cured, and gone to some other physician.

THE PREVENTION OF PREMATURE BALDNESS.

BY JOHN L. COFFIN, M. D., BOSTON, MASS.

Of all the minor afflictions which come to humanity, none is borne with less equanimity than early loss of hair. The rapid decline in the thickness and luxuriance of nature's head covering with the prospect of a "billiard-ball" pate or the alternative of a wig in the not distant future, fills many a heart with dismay and hurries them to the physician or the barber or the sure-cure advertiser, or possibly all three.

What can be done for these unfortunates? Sometimes much, sometimes little, often nothing. Many, many times it is the old story of locking the door after the theft. The mischief has been done or rather has been permitted and the result must inevitably follow.

These cases are not in the class where an "ounce of prevention is worth a pound of cure," but where a pound of prevention is the only cure, and therefore I have deemed the subject worthy of your attention and shall speak briefly of what may be done to prevent this annoying calamity.

We recognize as premature baldness or Alopecia prematura, loss of hair, more or less persistent, coming on before the age of thirty to thirty-five. These cases arrange themselves in two general classes, one class comprising those cases where there exists no disease of the scalp, Alopecia prematura idiopathica, the others comprising those accompanied by some disease of the scalp or symptomatic Alopecia, and in my own experience, the former class comprises mostly men, the latter class more women. Idopathic baldness is most often hereditary, descending from father to son, although not all the sons of one father may be afflicted. These patients come, as a rule, when the baldness is already more or less advanced, and for them but little, if anything, can be done, the hair papillæ on which the nutrition of the hair depends are atrophied or entirely gone and nothing can renew their integrity.

Those saddest words of Tennyson, "It might have been" are not inapplicable here, for many of these unfortunates might have been spared this misfortune had the danger been recognized and guarded against. Something can be done either to prevent or procrastinate this affliction by treatment, but the treatment should be begun the hour after birth and continued through childhood.

The vernix caseosa which covers the scalp at birth, should not be scrubbed off within an hour or two with soap and water, but the head should be oiled with olive or sweet-almond oil, and gently wiped with a soft cloth. If all the secretion be not thus removed it should be again annointed and left for twenty-four hours, when the same process should be repeated. After four days the head may be gently washed,

dried and immediately oiled, and in general it may be said that the scalp should not be washed oftener than every fourth or fifth day, and after each bath should be thoroughly dried and annointed. During childhood the hair should be kept moderately short (in girls until about the eighth year, after which it may be allowed to grow long) and the scalp should be washed only as often as the necessity for cleanliness requires. Daily sousing of the head in water should be absolutely prohibited, and the presence of excessive dryness of the scalp or beginning of dandruff shows a diseased condition which should be treated at once. There is no more fatal mistake than the constant shampooing of the scalp for the removal of dandruff. It does remove it for the time being, but it soon returns worse than before. If the children of parents prematurely bald were treated as to their scalps along the lines indicated above, I am sure the development of their inherited tendency would be much delayed, if not prevented.

The second class, Alopecia symptomtica is made up of those patients who present as a concomitant, some disease of the scalp, the most frequent being dandruff. Here the prognosis is more favorable, as the cure of the disease is generally followed by a cessation in the falling of the hair, and if the scalp has not been permanently damaged, a return of growth may be reasonably looked for. Besides dandruff, anæmia either localized in the scalp or a general anæmia, prolonged indigestion with consequent mal-nutrition; mental worry and anxiety; over-work of any kind, and in short, any cause which tends to lower general vitality may act to produce this affliction, and the treatment will be successful so far as we may be able to remove the cause and cure the local or systemic disease present. The prevention of these cases consists in the observance of the same hygienic principles for the care of the scalp as in the first class and in addition the early recognition and cure of dandruff.

DISCUSSION.

Dr. Lamson Allen: I think there is one cause of Alopecia that is well to bring to our attention, viz., it has been my experience that wearing a tall seal skin cap in winter time was the beginning of loss of hair with myself. In other cases I have found it to be the exciting cause. The heating of the scalp by such unhygienic wearing material I think, has been the cause of loss of hair in many people where there is no hereditary cause that can be found.

Dr. Coffin: In regard to the remarks of Dr. Allen about wearing a seal-skin cap, I have no doubt but that the cap has much to do with it, or anything that keeps the scalp abnormally hot. The stiff hat is also claimed to have something to do with it, the theory being that the stiff brim presses upon the blood supply of the scalp and con-

stantly cuts off the supply of blood. My own personal experience has been, that I did not begin to be bald until I wore a stiff hat, but I think it is coincidence more than anything else. Any head covering should be more or less ventilated. The more the air has access to the hair, the less liable are we to early loss of hair.

At 5.15 P. M., the Society adjourned to meet at Young's Hotel, where one hundred and fifty-nine members enjoyed the dinner provided by the Society.

LIST OF MEMBERS.

Names of Life Members are printed in Small Capitals.

Year.	Name.	Residence.
1890	Adams, George S.	Westboro
1866	AHLBORN, HENRY C.	258 Marlboro St., Boston
1898	Allard, Frank E.	685 Boylston St., Boston
1898	Allen, Edward E.	385 Main St., Charlestown
1892	Allen, Lamson	20 Elm St., Worcester
1890	Amsden, Henry H.	27 Park St., Attleboro
1856	ANGELL, HENRY C.	16 Beacon St., Boston
1890	Appleton, Lucy	160 W. Brookline St., Boston
1890	Austin, Clara C.	384 Commonwealth Ave., Boston
1859	BABBITT, WARREN M.	Randolph
1890	Babcock, Daniel A.	Fall River
1879	Babcock, Francis L.	Dedham
1876	Baker-Flint, Almena J.	102 Huntington Ave., Boston
1895	Barker, Emily J.	Wellesley
1894	Barnes, William E.	429 Dudley St., Roxbury
1891	Barstow, Benjamin P.	Kingston
1872	BARTON, J. MARCUS	796 Main St., Worcester
1894	Batchelder, Frederick P.	411 Massachusetts Ave., Boston
1895	Batchelder, Henry F.	Danvers
1885	Bell, James B.	178 Commonwealth Ave., Boston
1878	Bellows, Howard P.	229 Berkeley St., Boston
1892	Bennett, John H.	255 High St., Pawtucket, R. I.
1891	Bennitt, Francis M.	137½ State St., Springfield
1880	Blaisdell, James E.	Chelsea
1882	Bliss, George D.	151 Adams St., Dorchester
1888	Blodgett, Stephen H.	So. Lincoln and 419 Boylston St., Boston
1887	Bongartz, Walter E.	Beverly
1895	Bond, Aaron J.	Adams
1868	BOOTHBY, ALONZO	3 Worcester Sq., Boston
1889	Bosworth, John W.	Roslindale
1892	Bothfeld, J. Francis	148 Church St., Newton
1898	Boyce, Alvin	West Medway
1885	Brackett, Humphrey F.	230 Washington St., Brighton
1897	Bray, Amanda C.	4 Wellington St., Worcester
1891	Briggs, J. Emmons	204 Huntington Ave., Boston
1891	Brown, Daniel E.	Brockton

224 MASSACHUSETTS HOMŒOPATHIC MEDICAL SOCIETY.

Year.	Name.	Residence.
1897	Burpee, Carroll C.	5 Garnet St., Malden
1897	Butterfield, George W.	Wakefield
1899	Cahill, Eliza B.	Hotel Westminister, Boston
1887	Calderwood, Samuel H.	221 Warren St., Roxbury
1884	Carpenter, Edward A.	7 Linnaean St., Cambridge
1875	CARVILL, ALPHONSO H.	28 Highland Ave., Somerville
1893	Chalmers, Robert	Woburn
1899	Chapman, W. Louis	21 Waterman St., Providence, R. I.
1876	Chase, Herbert A.	950 Massachusetts Ave., Cambridgeport
1856	CHASE, HIRAM L.	924 Massachusetts Ave., Cambridgeport
1878	Chase, Joseph, Jr.	East Weymouth
1893	Childs, Helen S.	454 Centre St., Jamaica Plain
1890	Chipman-Palmer, Anna M.	Houston Ave., Mattapan
1879	Church, Adaline B.	102 Huntington Ave., Boston
1879	Church, Benjamin T.	Winchester
1871	CLAPP, HERBERT C.	384 Commonwealth Ave., Boston
1877	Clapp, J. Wilkinson	Brookline
1897	Clarke, Edwin A.	10½ High St., Worcester
1890	Clarke, Mortimer H.	Auburndale
1882	Clements, Lydia R.	Brookline
1880	Cobb, Harriet H.	1626 Massachusetts Ave., Cambridge
1880	Coffin, John L.	229 Berkeley St., Boston
1899	Colburn, Frederick W.	Holliston
1872	COLBY, EDWARD P.	845 Boylston St., Boston
1891	Coleman, Ellenwood B.	Nantucket
1892	Constans, Frank E.	Brockton
1871	CONANT, THOMAS	Gloucester
1897	Copeland, Elmer H.	70 Elm St., Northampton
1892	Coy, S. Willard	23 Princeton St., East Boston
1896	Crisand, Carl	2 Charlotte St., Worcester
1895	Crocker, H. Clinton	67 Common St., Providence, R. I.
1893	Cross, Grace E.	581 Broadway, South Boston
1866	CROSS, HIRAM B.	21 Seaverns Ave., Jamaica Plain
1880	Culver, Jane K.	2 Commonwealth Ave., Boston
1880	Cummings, M. Louisa	178a Tremont St., Boston
1899	Currier, Mary B.	191 Broadway Somerville
1866	CUSHING, ALVIN M.	187½ State St., Springfield
1897	Cushman, Mary Floyd	Castine, Maine
1885	Damon, Newcomb L.	405 Washington St., New Dorchester
1899	Davis, Anna B.	2 Commonwealth Ave., Boston
1880	Davis, Frank S.	Quincy
1892	Davis, Frederick A.	80 Huntington Ave., Boston
1895	Davis, Roland A.	282 Medford St., East Somerville
1885	Defriez, William P.	587 Washington St., Brookline
1858	DENNETT, GEORGE W.	South Framingham
1885	Devereaux, Jane S.	Marblehead
1870	DICKERMAN, SILAS B.	Abington

Year.	Name.	Residence.
1899	Diemar, Lena H.	1624 Massachusetts Ave., Cambridge
1896	Dike, John	Melrose
1894	Downs, H. Ashton	20 Dartmouth St., Somerville
1894	Dunn-Cary, Jennie S.	3 Rosemont St., Dorchester
1886	Dwinell, Byron L.	Taunton
1885	Earl, George H.	153 Newbury St., Boston
1890	Eaton, Samuel L.	Newton Highlands
1893	Elliot, Sydney B.	553 Boylston St., Boston
1893	Emerson, Frederick L.	50 Hancock St., Dorchester
1882	Emerson, Nathaniel W.	685 Boylston St., Boston
1893	Emery, W. Newell	749 Main St., Waltham
1895	Farley, William C.	Lawrence
1897	Farwell, Charles L.	384 Cambridge St., Allston
1897	Fessenden, C. H.	Newton Centre
1890	Fick, Herman A.	109 Warren Ave., Boston
1896	Fisher, Edgar A.	121 Pleasant St., Worcester
1893	Fitch, Edward D.	Philadelphia
1869	FLETCHER, WILLIAM K.	381 Cutter Sq., W. Somerville
1875	FORBES, GEORGE F.	17 Elm St., Worcester
1890	Ford, Nehemiah B.	Owasco, N. Y.
1879	Foss, David	Newburyport
1861	FRENCH, ALFRED J.	Lawrence
1892	French, Winslow B.	11 Columbus Sq., Boston
1899	Fuller, Solomon C.	Insane Hospital, Westboro
1878	Gale-Warren, Mary K.	Boston
1890	Gannon, Annie M.	41 Sawyer St., Boston
1888	Gardner, Frank A.	23 North St., Salem
1893	Garey, Charles W.	Quincy
1887	Gary, Clara E.	546 Columbus Ave., Boston
1887	Glazier, Frederick P.	Hudson
1894	Gleason, Charles S.	Wareham
1895	Green, Thomas W.	302 Chestnut St., Chelsea
1891	Grow, Timothy R.	Lynn
1891	Hale, Edwin Emery	North Attleboro
1879	Hall, Charles B.	Rockport
1885	Halsey, Frederick W.	272 Newbury St., Boston
1897	Hammond, Allen D.	Brockton
1887	Hammond-Field, Susan P.	90 West Springfield St., Boston
1885	Hanson, Wm. G.	Everett
1874	HASTINGS, CAROLINE E.	160 Huntington Ave., Boston
1871	HATHAWAY, WILLIAM F.	Weymouth
1897	Haub, Augustine C.	Parker House, Boston
1897	HAYWARD, JOS. W.	19 Garrison St., Boston, and Taunton
1896	Hayward, George W.	45 Hanover St., Lynn
1890	Higgins, Henry R.	12 Harvard Ave., Allston
1891	Hill, Lucy C.	492 No. Main St., Fall River

Year.	Name.	Residence.
1894	Hill, Noble H.	85 Huntington Ave., Boston
1897	Hines, A. Don	90 E. St. John St., San Jose, California
1898	Hinson, J. Miller	391 Boylston St., Boston
1897	Hodgdon, Frank A.	83 Salem St., Malden
1886	Hodgson, Mary C.	Stoneham
1866	HODGSON, RICHARD	Stoneham
1870	HOLT, EDWARD B.	Lowell
1892	Hopkins, Wm. T.	65 Broad St., Lynn
1895	Hornby, Mary S.	1 Monadnock St., Dorchester
1898	Houghton, N. H.	867 Boylston St., Boston
1899	Howard, Alonzo Gale	Centre St., W. Roxbury
1899	Howard, Charles T.	53 Mt. Auburn St., Watertown
1888	Hunt, Charles R.	New Bedford
1886	Hunt, L. Judson	1513 Washington St., Boston
1878	Jackson, William L.	76 Dudley St., Boston
1899	James, Lucille A.	222 W. Newton St., Boston
1891	Jenness, Sarah A.	741 Tremont St., Boston
1891	Jewett, Howard C.	Haverhill
1899	Jones, Everett	1618 Beacon St., Brookline
1892	Keith, Ellen L.	Framingham
1876	Kennedy, Alonzo L.	286 Newbury St., Boston
1886	Kimball, L. Houghton	15 Elm Hill Ave., Roxbury
1886	Kimball, Leonard M.	533 Columbus Ave., Boston
1883	Klein, August A.	2 Rutland St., Boston
1896	Knight, Edwin A.	West Newton
1891	Krauss, James	439 Boylston St., Boston, and Malden
1860	KREBS, FRANCIS H.	42 Union Park, Boston
1880	Lane, Robert L.	Somerville
1895	Leavitt, Forrest	808 Elm St., W. Somerville
1863	LEE, LUTHER M.	46 Adams St., Dorchester
1899	Lee, Wesley Terrence	258 Broadway, Somerville
1879	Leeds, Charles	1 Crescent Ave., Chelsea
1881	Leland, Clarence H.	Lowell
1880	Leslie, Freeland D.	Milton
1874	LIBBY, CHARLES A.	Arlington
1882	Lindsay, Jos. F.	The Warren, Roxbury
1888	Little, Harry J.	Norwell
1882	McDonald, Angus	124 W. Concord St., Boston
1895	Mack, Helen G. F.	149a Tremont St., Boston
1886	Mann, Martha E.	2 Commonwealth Ave., Boston
1897	Martin, George Forrest	17 Kirk St., Lowell
1899	Mason, Gilbert M.	208 Neponset Ave., Dorchester
1891	May, George E.	Newton Centre
1885	Moore, J. Herbert	Charles St., Brookline
1887	Morey-Pearson, Mary	361 Massachusetts Ave., Boston
1898	Morris, Frances M.	188 Marlboro St., Boston
1891	Morse, Charles W.	131 Essex St., Salem

Year.	Name.	Residence.
1875	MORSE, GEORGE	Gloucester
1891	Mosher, Mary E.	53 Blue Hill Ave., Roxbury
1892	Mudge, Kate G.	809 Essex St., Salem
1878	Murdock, Edward A.	Spencer
1888	Newton, Frank L.	147 Highland Ave., Somerville
1877	Nichols, Charles L.	38 Cedar St., Worcester
1887	Nordstrom, C. Maria	47 Washington St., Malden
1880	Packard, Horace	470 Commonwealth Ave., Boston
1882	Packer, Edmund H.	Bank Building, Shattuck St., Lowell
1880	Page, Charlotte E.	Braintree
1885	Paine, N. Emmons	W. Newton
1899	Parker, Ralph Walter	53 Central St., Lowell
1892	Patch, Frank W.	South Framingham
1874	PAYNE, FREDERICK W.	162 Boylston St., Boston
1863	PAYNE, JAMES H.	344 Commonwealth Ave., Boston
1879	Payne, John H.	Pierce Building, Copley Sq., Boston
1895	Pease, Ella G.	214 Commonwealth Ave., Boston
1893	Peasley, Emma J.	72 Central St., Somerville
1899	Percy, David T., Jr.	Arlington
1882	Percy, Frederick B.	Aspinwall Ave., Brookline
1880	Percy, George E.	359 Essex St., Salem
1880	Perkins, Nathaniel R.,	1122 Adams St., Dorchester
1891	Perkins, Archie E.	South Ashburnham
1891	Perkins, Henry P.	West Newton
1881	Perkins, S. Manning	20 So. Common St., Lynn
1891	Perkins, Wesley B.	
1892	Petersen, Henrik G.	85 Newbury St., Boston
1889	Pfefferhorn, Ferdinand C. L.	Lawrence
1895	Phillips, Eugenie M.	19 Highland Ave., Somerville
1891	Powers, A. Howard	352 Massachusetts Ave., Boston
1891	Reed, Clara D. W.	140 Church St., Newton
1893	Rand, John P.	Monson
1893	Rice, George B.	229 Berkeley St., Boston
1899	Rice, Harry E.	236 State St., Springfield
1895	Richardson, Edward B.	Rochester, Vt.
1880	Richardson, Frank C.	685 Boylston St., Boston
1880	Roberts, Oscar W.	4 Chestnut St., Springfield
1896	Robinson, Florence N.	21 Valley St., Lawrence
1899	Rockwell, John A.	3 Worcester Sq., Boston
1899	Rockwell, John A., Jr.	3 Worcester Sq., Boston
1880	Rogers, Charles R.	Plymouth
1894	Rogers-Rutter, Clara H.	228 Essex St., Lawrence
1878	Rollins, C. Abbie	Chelsea
1899	Rowe, Alice E.	183 State St., Springfield
1878	Russegue, Henry E.	95 Farmington Ave., Hartford, Conn.
1892	Russell, Julia A. B.	489 Main St., Malden
1893	Sampson, Lottie E.	Keens Mills, Maine

Year.	Name.	Residence.
1885	Sanborn, Emma M. E.	Andover
1880	Sanders, Orron B.	353 Commonwealth Ave., Boston
1867	SAWTELLE, GEORGE B.	Malden
1891	Sawyer, Willis H.	Ashmont St., New Dorchester
1859	SCALES, EDWARD P.	Newton
1899	Schubmehl, Frank E.	376 Blue Hill Ave., Roxbury
1871	SCOTT, CHESTER W.	25 Bradford St., Lawrence
1892	Scott, Cyrus W.	Andover
1893	Searle, George J.	Marlboro
1891	Sears, Eloise A.	58 Adams St., Waltham
1889	Seip, Charles L.	New Bedford
1886	Selee, Annie M.	105 Emerson St., Melrose
1886	Shaw, John C.	20 So. Sixth St., New Bedford
1882	Shaw, John J.	Plymouth
1876	Shaw, James S.	552 Tremont St., Boston
1875	SHERMAN, JAMES T.	29 Virginia St., Dorchester
1860	SHERMAN, JOHN H.	534 Broadway, South Boston
1877	Sherman, Sarah E.	11 Barton Sq., Salem
1862	SISSON, EDWARD R.	New Bedford
1886	Smith, Winfield	845 Boylston St., Boston
1883	Southwick, George R.	31 Massachusetts Ave., Boston
1867	SPALDING, HENRY E.	519 Beacon St., Boston, and Hingham
1881	Spalding, Samuel H.	Hingham
1899	Spencer, G. F. A.	Ware
1895	Stilson, Willard C.	629 Salem St., Malden
1886	Stone, Waldo H.	154 Orms St., Providence, R. I.
1893	Strong, Thomas M.	176 Huntington Ave., Boston
1871	STURTEVANT, CHARLES	Hyde Park
1892	Suffa, George A.	229 Berkeley St., Boston
1880	Sutherland, John P.	295 Commonwealth Ave., Boston
1893	Swain, Mary L.	178 Huntington Ave., Boston
1899	Sweet, Clara M.	2 Maple St., Springfield
1897	Swope, Dalva H.	Brockton
1875	SYLVESTER, STEPHEN A.	Newton Centre
1891	Talbot, George H.	Newtonville
1895	Talbot, Winthrop T.	Holderness, N. H.
1882	Taylor, Esther W.	15 E. Cottage St., Boston
1891	Taylor-Cole, Anna B.	34 Pearl St., East Somerville
1889	Thomas, Charles H.	427 Broadway, Cambridge
1877	Tobey, Walter H.	178 Newbury St., Boston
1880	Tompkins, Albert H.	20 Seaverns Ave., Jamaica Plain
1884	Tower, George A.	Watertown
1894	Townsend, Willis M.	Melrose Highlands
1891	Turner, Maurice W.	127 Harvard St., Brookline
1895	Tuttle, Walter	Exeter, N. H.
1899	Urich, John H.	432 Columbus Ave., Boston
1893	Utley, Edward R.	Newton

LIST OF MEMBERS.

229

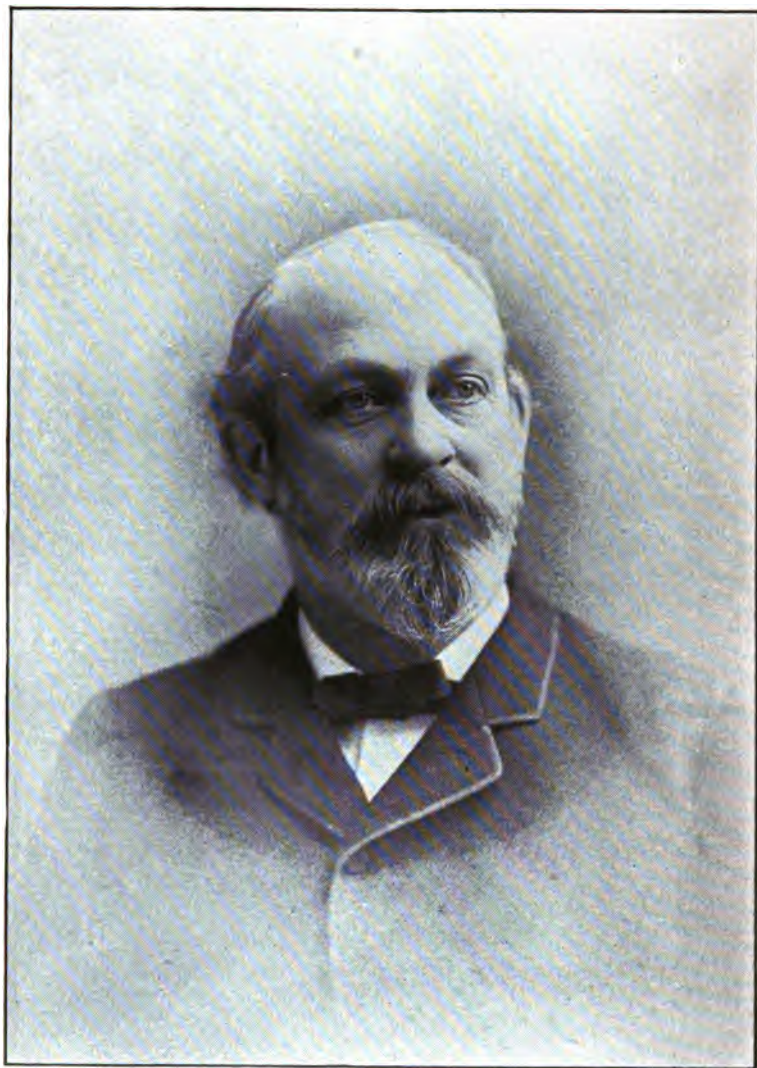
Year.	Name.	Residence.
1875	UTLEY, JAMES	Newton
1880	Vander Burgh, David W.	Fall River
1899	Van Deursen, George L.	17 Kirk St., Lowell
1892	Walker, Frank C.	108 High St., Taunton
1893	Wardwell, Percival G.	Beverly
1878	Warner, Frederick A.	56 Kirk St., Lowell
1899	Warren, Frank R.	68 Pleasant St., Worcester
1871	WARREN, JOHN K.	68 Pleasant St., Worcester
1898	Wells, David W.	391 Boylston St., Boston
1898	Wentworth, Caroline Y.	Newton Highlands
1858	WESSELHOEFT, CONRAD	661 Boylston St., Boston
1872	WESSELHOEFT, WALTER	26 Garden St., Cambridge
1893	Wesselhoeft, William F.	176 Commonwealth Ave., Boston
1858	WESSELHOEFT, WILLIAM P.	176 Commonwealth Ave., Boston
1856	WEST, BENJAMIN H.	Neponset
1888	Weston, Isabel G.	Wellesley
1875	Wheeler, Morris P.	Virginia St., Dorchester
1890	White, George E.	Sandwich
1885	Whiting, Walter B.	109 Summer St., Malden
1883	Wilder, Sarah E.	505 Columbus Ave., Boston
1891	Wilkins, George H.	Palmer
1898	Windsor, Sarah Sweet	188 Marlboro St., Boston
1895	Wood, Nelson M.	71 Elm St., Charlestown
1880	Woods, Charles L.	Lowell
1875	WOODS, WILLIAM	119 Berkeley St., Boston
1888	Worcester, George W.	Newburyport
1893	Worcester, John F.	Clinton

CORRESPONDING MEMBERS.

Year.	Name.	Residence.
1885	Allen, T. F.	New York, N. Y.
1885	Arndt, H. R.	San Diego, Cal.
1885	Beckwith, D. H.	Cleveland, O.
1885	Budlong, J. C.	Providence, R. I.
1885	Claude, A.	Paris, France
1885	Eckel, John N.	San Francisco, Cal.
1864	Fisher, Arthur	Montreal, Can.
1885	Houghton, Henry C.	New York, N. Y.
1875	Kavalgian, D. S. C.	Adapazar, Turkey
1880	Mellus, Edward L.	10 E. Chase St., Baltimore
1885	Oehme, F. G.	Roseburg, Oregon
1885	Orme, F. H.	Atlanta, Ga.
1896	Paine, Horace M.	West Newton
1885	Talcott, S. H.	Middletown, N. Y.
1885	Wright, A. R.	Buffalo, N. Y.

HONORARY MEMBERS.

Year.	Name.	Residence.
1885	Dudgeon, R. E.	London, Eng.
1885	Helmuth, William Todd	New York, N. Y.
1885	Hughes, Richard	Brighton, Eng.
1885	Jousset, P.	Paris, France
1885	Pope, Alfred C.	Grantham, Lincolnshire, Eng.



*Very sincerely,
J. T. Talbot.*

MEMORIAL

TO THE LATE

DR. I. TISDALE TALBOT,

HELD AT

ASSOCIATION HALL,

BOSTON,

October Thirtieth,

1899.

ORDER OF EXERCISES.

MUSIC, "Integer Vitæ," Horace, Ode XXII, F. Fleming

(By a chorus of male voices.)

"He who is upright, kind, and free from error
Needs not the aid of arms or men to guard him;
Safely he moves, a child to guilty terrors,
Strong in his virtues.

"What though he journey o'er the burning Syrtes,
Or climb alone the dreadful, dang'rous Gaimas,
Or taste the waters of the famed Hydaspes?
Gods will attend him.

PRAYER, Rev. C. H. Brent

INTRODUCTORY REMARKS, Frank C. Richardson, M. D.

President Massachusetts Homœopathic Medical Society.

ADDRESS, Wm. F. Warren, LL.D.

Representing Boston University.

ADDRESS, Col. Charles R. Codman

Representing the Laity.

MUSIC, "Forever Blessed," Mendelssohn

"Forever bless'd are they which die in the Lord, from henceforth,
oh blessed forever.
Thus the spirit saith to us, that they may rest from all their labor
and sorrow."

ADDRESS, Pemberton Dudley, M. D.

Representing the Profession at Large.

ADDRESS, Conrad Wesselhoeft, M. D.

Representing the Faculty of Boston University School of Medicine.

Music, "Chorus of Pilgrims,"

Wagner

"Once more, dear home, I with rapture behold thee,
And greet the fields that so sweetly enfold thee;
Thou, pilgrim staff, may rest thee now,
Since I to God have fulfilled my vow.
By labors long I have atoned,
And God's pure law my heart hath owned;
My pains hath He with blessing crowned,
To God my song shall aye resound.
Once more, dear home, I with rapture behold thee,
And greet the fields that so sweetly enfold thee;
Yes! pilgrim staff, thy toll is o'er,
I'll serve my God, forevermore. Hallelujah, forevermore."

ADDRESS,

J. H. McClelland, M. D.

Representing the American Institute of Homœopathy.

ADDRESS,

John L. Coffin, M. D.

Representing the Massachusetts Homœopathic Medical Society.

Music, "When for Me,"

Lewis

"When for me the silent oar
Parts the silent river,
And I stand upon the shore
Of the strange Forever,
Shall I miss the loved and known?
Shall I vainly seek mine own?

Can the ties that make us here
Know ourselves immortal
Drop away like foliage sere
At life's inner portal?
What is holiest below
Must forever live and grow.

He who plants within our hearts
All this deep affection,
Giving, when the form departs,
Fadeless recollection,
Will but clasp th' unbroken chain
Closer when we meet again."

FRANK C. RICHARDSON, M. D.
FREDERICK L. EMERSON, M. D.
JOHN F. WORCESTER, M. D.
F. P. BATCHELDER, M. D.
GEO. B. RICE, M. D.

Committee of Arrangements.

INTRODUCTORY ADDRESS.

BY F. C. RICHARDSON, M. D.

Ladies and Gentlemen: In the preparation for this Memorial your committee has been especially impressed by two facts; namely, that those who gathered here this evening would represent but a small fraction of the very many men and women throughout the world who would gladly unite with us in a tribute to the memory, of Dr. Talbot, so far reaching has been the influence of his life. Again, that that influence is not of transient character, but that it must leave upon all our affairs a lasting impression; not alone by reason of the good work accomplished, but because of the inspiration his life has afforded to others. Although we have been deprived of the fellowship of a leader, a colleague, a friend, we have still to guide and stimulate us the memory of his well spent life; and the meeting this evening should have a two-fold object, not only that we may pay tribute to the memory of that life, but also that we may have more fully impressed upon us its inspiring example, its steadfast purpose, its splendid accomplishments. The trials, the heartaches, the sacrifices incident to such a life are too sacred for our consideration, but we are privileged to dwell upon its grand achievements. Our meeting therefore, should not be of sombre tone, but on the contrary, triumphant in the knowledge that there has lived amongst us a good man, who, to our lasting benefit, has fulfilled to the utmost the high destiny of his life, the guiding precept of which has ever been responsibility to God and duty to his fellow man. With such thoughts as these in the minds of speakers and hearers, this occasion cannot, I am sure, fail to be edifying in the highest degree to all those who participate.

ADDRESS OF WM. F. WARREN, LL.D.

President of Boston University.

In order that I may be certain not to over pass the time-limit which every speaker on so extended a programme as the present ought carefully to observe, I have put in writing what my heart prompts me to say of the beloved friend whom we are met to honor.

Israel Tisdale Talbot was first of all a manly man. In all the years of my association with him, I never knew him to betray an ignoble aim, or to resort to an unworthy measure. As a consequence he was trusted; and this unwavering trust in his manly honor was the foundation of his wide and ever wider influence.

Again, his self-regimen was notable. The first time I ever saw him was under circumstances in which, by reason of an apparent invasion of his professional prerogatives by another, few men could have retained the coolness of self-control. His deportment under the extraordinarily trying conditions evidenced a self-mastery rarely met. To this hour I have retained the impression then made upon me.

The history of the movements which led to the opening of the Medical Department of Boston University in 1873 have been outlined in a memorial Minute adopted last summer by the authorities of the University. It is too long for rehearsal here. From the opening of the Department till the date of his death, Dr. Talbot was annually elected by the Trustees to the Deanship of the Faculty. In this position he showed rare skill and a loyalty to the University's interests worthy of one who had been the beloved family physician of at least two of its founders. As a teacher he was able; as an administrator, tactful; as a counselor, beloved. He was a firm believer in co-education. At the time of the struggle for the opening of facilities for college preparation to girls in Boston, he rendered the cause of progress a valuable service. Many a man would have shrunk from the risk and responsibility of conducting the then untried experiment of co-education in medical and surgical instruction; but he did not. The issue abundantly vindicated his faith and courage. He lived to see the newest and strongest institutions, universities like the Johns Hopkins and Cornell, following the example first set in Boston University.

Dean Talbot was by instinct a leader. He was ready for the highest practicable advances. Accordingly, when it was suggested that the time had come to advance the standard of medical education in America by establishing a curriculum four years in duration, in place of the meagre courses of two, or at most three years, then maintained in the old institutions, he saw the need and the waiting opportunity, and under the inspiration of his advocacy not only his colleagues in our faculty were won to the measure, but also in a short time the governing authorities of the Homœopathic colleges throughout the country. Had he been less responsive to high ideals, Boston University would have missed the honor she now enjoys of having been the first of American institutions to provide and maintain a four year's course preliminary to a doctorate in medicine and surgery.

Some leaders accomplish their victories by organizing cliques and parties, and so giving to partisan aims and enthusiasms the concentration and force of organization. Such victories are always partisan and seldom permanent. Dean Talbot's broad spirit chose nobler aims and wiser instrumentalities. He discountenanced narrowness of every sort. He opposed carrying even the college feeling, college badges, college headquarters, and such like into the State, national, and international conferences. He strove to unify all interests, all local and personal forces, in harmonious co-operation for the good of the profes-

sion, and for the benefit of the public. The abundant testimony as to his success will be given you this evening by many witnesses.

The generosity of his nature revealed itself in many an experience of his active life. He loved to praise the merits and the successes of his many colleagues. Only a day or two ago I unexpectedly came upon a letter of his written from New Hampshire two years ago last Saturday. He had just returned from his year in Europe. I had sent him upon his arrival a note of welcome and of congratulation on the improved condition of his health. His reply well illustrates his habitual love of his colleagues and his habitual delight in their successes. He says:

"I had hoped ere this to pay my respects to you in person, but though I am much better than when I went away yet I have not the strength to do a tithe of the things for which I have the inclination.

"It is a great satisfaction to be at home again among the activities and to see others do well what I cannot perform. It has been a great source of rejoicing to me that affairs connected with the School have gone on so well in my absence. I am delighted to find in Dr. Sutherland a man of so much keen insight and executive ability in his relations to the students, and should feel no hesitation in relinquishing my duties to him, assured they would not in any respects suffer at his hands."

How loyal and spontaneous a word was this. And it was spoken in ready recognition of a colleague young enough to have been his pupil in the earlier years of the School. In the very next paragraph he goes on as follows:

"We have a superb set of men in the Faculty, earnest, conscientious, painstaking and ambitious to do the best possible in their work."

Instead of supposing that the School must have missed him during the year and suffered from his absence, his indestructible modesty and optimism prompt him to say: "The standard of instruction has steadily improved from the beginning and perhaps at no time more than during the past year."—What wonder we all love so unselfish an associate, so generous a friend.

Such was the man who, in the maturity of his powers and influence, has been taken from us. Well may words of honor and affection be spoken on both sides of the broad Atlantic. In the words of Matthew Arnold by the grave of his father fifteen years after the separation, many a questioner will cry:

O strong soul, by what shore
Tarest thou now? For that force
Surely, has not been left vain!
Somewhere, surely, afar
In the sounding labor-house vast
Of being, is practised that strength
Zealous, beneficent, firm!

Yes, in some far-shining sphere,
 Conscious or not of the past,
 Still thou performest the word
 Of the Spirit in whom thou dost live—
 Prompt, unwearied, as here!
 Still, like a trumpet, dost rouse
 Those who with half-open eyes
 Tread the border-land dim
 'Twixt vice and virtue; revivest,
 Succourest! — this was thy work,
 This was thy life upon earth.

ADDRESS OF COL. CHARLES R. CODMAN.

I am here to speak of Dr. Israel Tisdale Talbot as his neighbor and his friend, and as having had exceptional opportunities, from much confidential intercourse with him, of knowing and understanding the motives that influenced his actions. It is, however, comparatively recently that I have been brought into intimate relations with him. I know nothing, except by reading their records, of the active controversies of his early medical life; but since I have known the man for a period of now more than twenty years, I have become convinced that it was from no love of strife and contention that he was foremost and most aggressive in the advocacy of the cause in which he believed. Nothing but love of the truth, as he was given to see it, and a consuming desire that his fellow-men should receive those benefits which the new system of therapeutics seemed to him to promise them, could have led him to give so much time and such untiring energy to its propagation, and to make other sacrifices greater to him than the loss of time or of money. More than once I have heard him express his sorrow that fidelity to his convictions had compelled him to part company with the larger number of his professional brethren. Let no one imagine that he did not keenly feel the obloquy and the contempt that so many of them exhibited towards him. I know that it saddened him, and I also know the dignity and the courage with which it was endured. If it never checked his zeal for his cause, it was because he was fully possessed of the true spirit of the martyrs. He could be brave not only against open and violent assault, but, more than that, he was ready to give up social amenities and personal friendships, and to submit to cold looks and constrained behaviour from those whose sympathy and regard he would have been only too glad to retain.

But as time went on old prejudices and animosities became modified, and Dr. Talbot was with us long enough to "live" them down.

He continued his propaganda to the last, faithfully and vigorously. He never stooped to personal abuse; he called no names; but he never relaxed his efforts, and never lowered the standard that he carried. There was no one of his most censorious critics that he was not willing to forgive; there were no overtures towards peace and conciliation that he was not ready to welcome; and if he did not hold professional intercourse with his brethren of the "regular" school, it was because they, and not he, refused it. He came at last to command their respect, but he never made a concession that could compromise the cause for which he stood.

In these times when the "odium theologicum" has passed away, and when even the "odium medicum" has lost much of its virulence the younger members of the medical profession and of the community can hardly realize the bitterness that was felt and expressed towards the homœopathists less than fifty years ago. If all this has been changed for the better, and if hostility has given way to more kindly feeling, it only proves that courage and sincerity are sure at last of appreciation and of respect.

The pioneers in a worthy cause often have to trust to posterity for their vindication, and to leave the world apparently no better than they found it; but it was Dr. Talbot's singular happiness to live long enough to see and to enjoy the fruits of his persistent and self-sacrificing efforts, an experience that is not given to all reformers.

It may be said of much the greater part of the institutions and societies for the advancement of homœopathy in this country with which Dr. Talbot was concerned, that they have attained success within the period of his activity. Of none is this more true than of the Massachusetts Homœopathic Hospital, an institution of which I may speak from an intimate knowledge of twenty years. This is not the proper time to detail the good work that it has done, which is well understood and recognized by the people of Boston. It is enough to recall its humble beginning when, in 1870, the Corporation hired and fitted up a small house in Burroughs Place as a hospital for sixteen patients; and to point now to the stately and well-equipped building on East Concord and Stoughton Streets, in which is given the best medical and surgical treatment to two hundred patients.

Dr. Talbot has served this institution as one of its founders, as its most active promoter and advocate, as an officer in its government in the capacities of Trustee and Director, and as a member and Chairman of its Medical Board. His activity and energy were unbounded in all these departments. His large private practice never prevented his giving full attention to all the duties imposed upon him by his connection with the hospital. These duties included not only the great professional responsibilities which, as a physician and surgeon he might have been expected gladly to assume, but also the business administration of the hospital, in which he always took the leading and the most active part.

The largest gifts that the hospital has received have been due to his tact and wisdom in laying its claims before those generous members of our community, who have been its benefactors. He has been its successful leader in all its applications to the State or the city for financial aid. He shrank from no details; and those things that no one else could or would do, he was always ready to take upon himself, however trivial and however burdensome. And we know well that the same conscientious thoroughness marked his care of all the institutions in which he had any interest as representing the homœopathic school of medicine. It was indeed amazing how much work he did, and how well he did it up to the very end of his toilsome life.

I must not fail to speak of Dr. Talbot as a family physician in which capacity I have known him since 1878. Nothing could exceed his attention or his care; and, as a somewhat late believer in the advantages of the homœopathic system, and therefore as one who has had experience of non-homœopathic methods, I must give my testimony to his singular success, where others seem to me to have failed. He was a physician of sane and sound judgment, and he knew well how to bring his large knowledge and experience to bear upon his cases. His consideration and his tenderness for those whom he attended were very great, and he never manifested impatience or irritation when his patients or their friends misjudged him as a physician. I suppose that physicians are often misjudged, but I am sure that all do not bear injustice with the same magnanimity that I have seen in Dr. Talbot.

But when all this has been said, what is it that is most worthy of our admiration in the man whose memory we would honor tonight? It is not only the singleness and honesty of his purposes and his unwearied persistence in carrying them out, nor even the natural power of his intellect and of his will which was far above that of ordinary men, but it is rather his highminded unselfishness. The desire to relieve suffering was the great motive that animated his life. If he threw his whole soul into what he believed was a needed reform, it was neither because he loved controversy, nor because he coveted fame and reputation. It was the actual suffering of the men and women that he saw, which he thought was not sufficiently alleviated or prevented by the old therapeutic methods that kindled and sustained his desire for the success of his cause; and, as it gained ground in the respect of his fellow citizens and he saw it heartily approved by many laymen of character and intelligence, intense as his satisfaction must have been, he never gave utterance to a word of personal triumph.

It is not surprising that his loss to the cause is deplored everywhere, and that testimonials of regard and sorrow come to us from across the seas.

We commemorate today a man of perfect integrity and of lofty motive, who has done his life's work, and has performed faithfully

and fully the duty that his conscience and his convictions laid upon him. Surely there can be no better eulogy than is expressed by these simple words:

After life's fitful fever this brave champion and leader sleeps well. He has outlived and conquered the honest prejudices of many honest men, and he leaves a name unstained and altogether honorable. Those who follow him and who are to continue his work may well feel the inspiration of his example. He has shown what great things a single man can do who never flinches, who never despairs, and who is always conscientious. Peace to him as he enters into the immediate presence of the Master! May he have many earnest followers as brave and as devoted as himself.

ADDRESS OF PEMBERTON DUDLEY, M. D.,
PHILADELPHIA, PA.

Let me, at the beginning of these remarks, express my appreciation of the Executive Committee's kindness in permitting a tribute to the memory of Dr. Talbot from one who had been honored with his personal friendship for nearly twenty years, and who had been guided by his kindly, yet faithful, criticism and sagacious counsel in more than one period of difficulty and uncertainty. The departure of the distinguished physician who is the subject of our thoughts to-night, brings to me, as to so many others, a sense of personal loss and bereavement.

But I am here to speak, not for myself, but in behalf of that large body of humanitarian toilers of which Dr. Talbot formed so conspicuous a feature and who owe to every such leader as he was, a large meed of admiration and a large debt of gratitude.

It is proper that mention should here be made of the fact that our departed colleague was an alumnus of the Institution with which I have the honor to hold official relation, and that his character, his scholarship and his life-work have reflected high credit upon his Alma Mater and made her justly proud of her relationship to her distinguished son. And yet, Dr. Talbot's interest in medical education was too broad to be restricted to any single institution. He belonged to all the twenty Homeopathic Colleges of the United States and labored earnestly for the efficiency and prosperity of all of them.

In the Chronicles of the ancient Hebrews, in the course of a history of general unfaithfulness on the part of official leaders, and of indifference on the part of their subjects and followers, there springs into almost startling prominence, the story of a faithful, devoted, laborious, self-sacrificing priest, whose only official thought seems to have been to lift up his people and bring them under the protecting favor of the Almighty. We read that when the faithful Jehoiada died, "they

buried him in the city of David, among the kings, because he had done good in Israel." These ancient, and not very cultivated people must have recognized a principle that even some of their descendants are prone to forget: that true kingliness of character finds its expression and its province in that form of leadership which thrusts aside self and selfish ambitions and seeks only to elevate and bless others. No matter where, or amid what surroundings of natural beauty or of artistic taste, the mortal remains of Dr. Talbot await the resurrection call, in the hearts of them who knew him best and comprehended him most, his memory is enshrined among the kingly ones of earth, "because he had wrought good in Israel." For a memorial eulogium of such a man as he, what text more appropriately suggestive could be chosen than the simple words—"They buried him among the kings."

It is difficult to separate a worker from his work. That men make history is not more true than that history makes men. The man is a part of the event; the event a part of the man. Every reminiscence of Dr. Talbot brings up before the mind the great medicinal school, the hospital, the medical journal, the local, state and national societies, the inter-collegiate organization, the elevation of medico-educational standards, the co-education of the sexes in medical colleges, the advocacy of philosophical methods in medical instruction and the battle in defence of liberty of conscience in medical practice. Whenever, to one familiar with recent medical history, the name of Dr. Talbot is mentioned, some one or more of these great, beneficent movements and enterprises comes before the mental vision as if to complete the picture of the man. We cannot disassociate him from what he accomplished.

It is very easy to judge the quality of certain great public movements by the character of the men who originate and propagate them. Conversely it ought to be possible to explain the character of a public man by the nature of the tasks and projects to which he applies his thoughts and energies. We who knew the quality of Dr. Talbot's inner nature, are not surprised that after his practical manifestation of interest in his own Alma Mater and in the great school he aided in founding, his unsatisfied aspirations still reached forth to uplift all the Homœopathic schools in existence and to elevate educational ideals all over the land. The man's character explains his work. Will not the man's work also explain him? What was Dr. Talbot, aside from his more public activities? What was he before—what was he underneath these labors and enterprises? What was in him to make him concern himself in enterprises of such peculiar pith and moment? We are speaking for the profession at large — and the profession is concerned — deeply concerned in learning how such men are produced, and out of what sort of material. We see in him, a man of clean lips and of pure life; of kindly disposition and of courtly bearing; of fine literary taste and scholarship and of broad scientific

attainment; of skill and devotion in his professional duties, and of all the qualities that are essential to the make-up of the successful physician. But no one of these admirable qualities nor all of them combined could have made him so influential a leader in professional progress and in the educational and benevolent enterprises in which he was so peculiarly distinguished. In connection with all his more external qualifications there must have existed an inner consciousness of the almost divine import of his professional relations and responsibilities—a conviction that his mission was exalted, and that his field was the world of humanity lying in the throes of disease. When, with all his energy, he entered into the movement to establish the Massachusetts Homœopathic Hospital, he was well aware that to him it meant anxious hours, toilsome days and sleepless nights; that it involved the sacrifice of private business, the expenditure of private means, and the diminution of the hours to be spent amid the delights of the home-circle. Only the broadest humanitarian spirit could have impelled him to such an undertaking.

The key to an understanding of Dr. Talbot's public career, then, is not to be sought in his brilliant capacity, his comprehensive outlook or his tireless energy; though these were doubtless essential to the wise formation of his plans and the successful accomplishment of his purposes. Undoubtedly the primary and foundational factor in determining the quality and extent of his public service and the distinction he attained, was an extraordinarily accurate and exalted conception of the medical man's responsibility and of his relation to human happiness and welfare. Resting upon this conviction there must have been ardent hope, high purpose and indomitable courage. These were the fundamental elements in the building up of his high character and in determining his extraordinary career of public and professional usefulness. And it is to these qualities and characteristics that we must primarily attribute the historic fact that Dr. Talbot's name, and his noble deeds, are to-day known and honored and loved throughout all the borders of the American and European civilization. True it is that Dr. Talbot's entrance into medicine occurred under conditions better adapted to nurture and develop the finer and nobler aspirations and purposes than are those that influence the young physician of the present day. There was less temptation to forget the higher and holier objects of medical study in the mad struggle to acquire the ability to answer all sorts of questions from memory, and to pass all sorts of examinations. There was less of the spirit of medical commercialism to allure him and less of the crude and repressive spirit of legalism to irritate and embitter him. He was regarded more as the coming friend of the poor and the suffering and less as an object of governmental suspicion. Beyond all question the practice of medicine presented far more favorable conditions for the development of the spirit and habit of public and private benevolence in those earlier days than it does now.

It must not be assumed that these moral attributes of Dr. Talbot's character, to which we are ascribing so much influence in the determination of his career were combined in a sort of flabby, namby-pamby sentimentalism. Very far from it! Dr. Talbot's whole being was full of alertness, plan, purpose, determination, courage, fearlessness. He was in more than usual degree one of the sort of men who bring things to pass—not a dreamer, but possessed of executive energy in every fibre of his being. This was peculiarly and beautifully illustrated when in 1873 the battle for freedom of medical opinion and practice was fought in the Supreme Court and—lost; and when Dr. Talbot and his handful of associates, quick to discern and interpret the drift of popular sentiment and sympathy, wrung out of the very jaws of defeat that mighty victory, the establishment of the Massachusetts Homœopathic Hospital and the Boston University School of Medicine. It constituted, not merely the creation of a system of Homœopathic education for all New England, but the centre of an uplifting influence which is felt in every medical college throughout the United States. It was the most blessed defeat that Homœopathy ever enjoyed, and its magnificent results exhibit Dr. Talbot in a light that can be adequately expressed by but a single term—"Genius."

To the young physician, what a lesson is presented in the life and character of this distinguished man! Many a brilliant young practitioner has failed to reach the goal of his ambition or to justify the expectations of his friends, simply and only because he lacked the requisite moral qualities. Medicine is a means, not an end. The physician's realm is a realm of service. A greater Physician than Dr. Talbot once said, "If any man will be great among you let him be your ministering servant." In the domain of medical practice, the Master's rule is not only imperative; it is also nearly or quite unfailing. The pathway to medical distinction lies directly through service and self-sacrifice.

Let us be thankful for such a character as the one we are paying honor to to-night: thankful for such a career, for such a man; and let our humanity earnestly invoke the God of all grace for more men like him.

ADDRESS OF CONRAD WESSELHOEFT, M. D.,
BOSTON, MASS.

As it is my privilege to speak of Dr. I. T. Talbot in behalf of the Boston University School of Medicine, it seems to me that I can best fulfil this request by alluding to Dr. Talbot's connection not only with that school but also with the various organizations in which he had been so influential for so many years; at the same time permit me to allude to the methods of his work and his great ability in performing it.

My associations with Dr. Talbot dating back for more than forty years, enable me to call back in memory various phases of his influence during that time. My first acquaintance with him began in '57 or '58 at the meetings of the Boston Academy of Homœopathic Medicine, a small society compared with our societies of today. Fifteen or twenty of us would come together to talk over our plans, and the best methods of treating the sick. It was a common experience in those meetings that Dr. Talbot's presence always infused new life and energy into the proceedings which were apt to lag in his absence. This, however, was very rare indeed. This society continued until it took a new departure by becoming merged into an organization known today as the Boston Homœopathic Society. Omitting the details of how all this came about, it is only necessary to say that at that time it was moved and carried to do away with the idea that homœopathy was merely a creed, and that it was an established method of therapeutic science. Dr. Talbot, though not the originator of this movement, was most influential and enthusiastic in establishing the homœopathic medical society on this more liberal basis in accordance with which, and contrary to previous usage, and contrary to the usage of the other school, all well accredited physicians could be admitted without pledging themselves to a belief, so long as they agreed to work on the lines laid out by the society. It is easy enough to suggest an idea, but to make practical application of it, is not the gift of every one. Dr. Talbot possessed it in a high degree, and to his aid the Boston Homœopathic Medical Society is indebted to the honor of being the first of its kind to enjoy a constitution and by-laws which declare science to be free.

In connection with the organization of the Boston Homœopathic Medical Society, I recall the time in '57 or '58 when the need of a homœopathic dispensary began to be felt by the public as well as by physicians. That idea was at once taken up by Dr. Talbot and most vigorously acted upon. You may remember what fairs were in those days; they required a great deal of work and realized but small amounts of money, so that eight or nine hundred dollars were considered as a successful result. Dr. Talbot thought otherwise, for he saw in it an opportunity to realize much more, and the result exceeded even his expectations, because that first fair for the dispensary netted ten thousand dollars which formed the nucleus of the present property of that institution. Many of you who are present will remember the skill and industry which Dr. Talbot displayed at that time. But you will remember more distinctly because it is nearer in point of time, the greater event which followed, and to which the speakers before me this evening, Col. Codman and Professor Dudley, have so aptly alluded. The trial of the homœopathic members of the Massachusetts Medical Society and their expulsion from the same—it must have been in the seventies—led to a general uprising of the friends

of homœopathy which resulted in another great fair, greater than was ever held anywhere. In this, as in the previous one, Dr. Talbot took the lead in its organization, seeming to be everywhere at the same time. The fair lasted a whole week, and netted its promoters no less than eighty-five thousand dollars, a sum unheard of thus far in the annals of fairs. I remember how much we were all interested, and how that interest was stimulated by Dr. Talbot's example, method and practical tact. He showed us just how to do it, and it was so easy to do it under his guidance, it was one of those achievements in which he was the moving spirit; still he did not seem to be very prominent; one saw more of those whom he had set at work than one saw of him.

But I think that the most important work of Dr. Talbot's life, and one which he carried out and perfected to the highest degree, was the Boston University School of Medicine. The plan of such a school had slumbered with us for some years since it was first broached, I think in 1850. Nothing was done about it except that when it was mentioned it was always received with a good deal of appreciation; but there was one of us with whom that suggestion grew into a firm resolution, and when the time had ripened it, the college was organized. It came about through fortuitous circumstances of a medical school for women; desiring to dispose of its grounds and buildings, it was at once seized upon and secured, chiefly through the forethought and practical skill of Dr. Talbot, who, upon its organization, became Dean of the faculty of this now flourishing medical school, and retained this office up to the time of his death with great credit to himself and to the entire satisfaction of all connected with this institution. In this connection the names of David Thayer, E. B. de Gersdorff and D. G. Woodvine who have all gone before, deserve to be mentioned.

I was asked to speak also of Dr. Talbot's methods of work, and think that the whole secret of his success lay in his energy and tact combined with method and foresight. Thus he would proceed to see personally every man and woman within his reach in the profession, and arouse their interest in his plans. That was one great factor. His next step would be to get the community at large interested. This he generally did by sending out circulars. These seemed to some perhaps perfunctory and insignificant, but the sender knew their purpose for the way had been prepared for them; they told everybody just what was to be done, and prepared peoples' minds for the event. Still another step was to call a meeting. Now, there is always a great deal of difference between meetings where everybody is informed and well posted as to the object of the meeting, and those in which nobody knows the object and only comes from curiosity if he comes at all. In those meetings called by Dr. Talbot, everyone knew just what was wanted and what was to be done, and the result

was harmony, decision and rapid transaction of business, for everything had been prepared by one mind that knew how to impress others. These principles played a great part in Dr. Talbot's manner of organization in regard to the dispensary, hospital and college, while in the organization of societies he proceeded on a plan adopted by him in the reorganization of the American Institute of Homœopathy. This institution had languished somewhat for several years. The attendance was small, and the meetings were held at irregular periods, especially during the war, when for a year or so no meetings were called up to the time of the memorable one at St. Louis, when new life was infused into this work by Dr. Talbot's skill in organization, and the Institute today, instead of having on its rolls a few hundreds, now counts as its members nearly two thousand homœopathic physicians of the United States. This was done by crystallizing the various branches of science into groups or sections, each section having its chairman and secretary. The result was a great increase of very progressive work in which not only the materia medica but all branches of medical science were represented. The plan was that of Dr. Talbot, and in the execution of it his methods were followed.

At one time the interest in our local society failed somewhat, but Dr. Talbot's watchful eye soon saw and remedied the fault. Thus one evening he appeared with a paper of rules and reformatory by-laws which, though introduced in the most quiet and perfunctory manner, soon infused new life and ambition into the meetings which have ever since been most profitable. While before this time the work done at these meetings was of a most desultory character, it now became regular and interesting under the supervision of chairmen and active secretaries, and the attendance all that could be desired.

In closing, let me say that we shall cherish the memory of our dear friend as long as we live, and shall always allow the spirit of the works he had inaugurated to guide us henceforth.

ADDRESS OF J. H. McCLELLAND, M. D.,
PITTSBURGH, PA.

It is a fitting thing that we should gather from near and far to strew flowers upon the last resting place of our dear friend; to speak of his worth and achievements and to pay tribute to his revered memory.

I have been asked to refer to Dr. Talbot's work in our national body, the The American Institute of Homœopathy.

Looking over the flood of years, memory brings to mind my first impressions of the men, and the work of the American Institute. This was in June of the year '66 at the session which met in my native city. As an undergraduate I was not yet eligible to membership, but

I was none the less interested in taking the measure of those whom I found engaged in the active work of the session, and with whom I was later to be associated.

There were Dake and Ludlam and Helmuth, Kellogg, D. S. and H. M. Smith, Paine, Belcher, Wesselhoeft, McManus, and many more who had earned place in the front rank of their profession. It was a time of reorganization after the interruption caused by the Civil War. The earnest men of the Institute were endeavoring to get the machinery in order for active work, measures were being discussed, and the future operations of the Society outlined. It soon became evident to me from my position as a semi-outsider, that the man of the hour was Dr. I. T. Talbot of Boston.

He seemed to take in every situation at a glance, and in debate his reasoning was logical and forceful. I was drawn to him by his evident sincerity of purpose, and unflagging enthusiasm in pursuit of the objects in view.

To be sure, I worshipped from afar off, for I did not then presume upon a close acquaintanceship, but, during all the years since, as my knowledge of the man has increased and my friendship grown closer the opinion then formed has remained unchanged. Nay, a nearer and clearer knowledge of the man, his character, his work and his attainments, have but served to increase my love and admiration. Emerson says, "It is natural to believe in great men," and "when nature removes a great man people explore the horizon for a successor, but none comes"—and I fear none will.

The service of Dr. Talbot in the American Institute was long and honorable. He became a member the year of his graduation in medicine from Old Hahnemann in the famous class of 1853. He was a believer in the value of organization, and early devoted his talent to the upbuilding of our national body. He found it, as a society, few in membership and without a definite purpose. He, more than any other man, made it a mighty engine for the uplifting of his profession, having for its avowed purpose the general advancement of medical science.

Strong in belief that "The destiny of organization is the achievement of great ends—quite impossible to individual efforts," he devoted his matchless energies to the work of creating a distinct advance along the whole line of professional attainment. The committee on reorganization which reported at this meeting in 1866, consisted of Drs. Talbot, Dake, Helmuth, Witherel and D. S. Smith and history tells how well they succeeded. A little later the contest for higher and better scholarship was inaugurated. It was then Dr. Talbot led, with an intrepid leadership, the heroic struggle for higher medical education, and succeeded in securing through the powerful influence of the Institute, advanced requirements for graduation, with unbroken uniformity in all our colleges. So that, beginning with the Boston Uni-

versity School of Medicine, which was practically his own creation, and of which he was the honored Dean,—a greatly extended course of medical instruction was first required by the Homœopathic Colleges of our country. They became pioneers in the cause of medical education and secured the honor of being the first Medical Colleges in the United States which made a four years course obligatory.

He also did much to secure suitable legislation in and out of the Institute, both as a member of the Legislative Committee, and in his individual capacity.

He was ever on the alert lest legislation inimical to our school should prevail, and exerted all his energies toward securing enactments that were just and equitable to all. While the young giant Homœopathy was his special care, he was ever just in his respect for the rights of others.

For almost a life-time he devoted unstinted labor upon the work of the Bureau of Organization, Registration and Statistics, formulating plans and carrying many of them into effect. Enormous labor was necessary for the gathering and arranging of data in this department, but he never shirked from assuming his full share of the burden.

In an index being prepared by Dr. Henry M. Smith of New York, of the papers and debates of the American Institute, page after page is devoted to recording the work of Dr. Talbot. We find scarcely a volume in all these years (forty-six) that does not contain valuable contributions from his pen. The mere naming of them would require more time than there is at my disposal.

The Bureau of Surgery comes in for many of these important contributions. We find he early recognized the value of Antiseptics in surgery, and among the instructive papers from his hand are the following:—on Spinal Curvature, Hernia, Staphylorrhaphy, Perineorrhaphy etc., etc.

Dr. Talbot's ability was recognized not only on the floor where he was earnest, logical, convincing and always courteous, but also for his excellent judgment as a presiding officer. His enormous capacity for committee work, was so well known that he was in constant demand for this arduous service. Long after adjournment, away into the night, it was his wont to labor over any task that was assigned him. As a result of this, a report coming from him was thoughtful, comprehensive and to the point. Dr. Talbot's capacity for work was something extraordinary, making applicable to him, Cecil's remark concerning Sir Walter Raleigh, viz: "I know that he can toil terribly."

He served the Institute with conspicuous ability as President in 1872,—having previously declined the honor when it was sought to be conferred.

He was chosen Vice President in 1865, was for years the General Secretary; and had previously served as Provisional Secretary.

When it was proposed to erect a memorial to the memory of Hahne-mann, Dr. Talbot, by my request, was placed on the Committee. He

entered earnestly upon the work and gave most valuable assistance in the delicate task of selecting a design. His last letter to me written but a day or two before his death, was full of encouragement, and promise of active help this coming winter.

I had the honor of being associated with him recently in the effort, successfully made, of securing the adoption by the Institute of the original rendering as given by Hahnemann of his famous dictum, "*Similia similibus curantur.*"

Thus in whatever capacity he was called to serve, he conscientiously did his duty, giving freely of his time and best energies. He never sought office or preferment, but was ready for work always.

In the International congresses he was an acknowledged leader, and was largely instrumental in their success. He was President of the preeminently successful Convention held at Atlantic City, 1891.

That the American Institute of Homœopathy owes its present commanding position to Dr. Talbot more than to any one who has ever been enrolled in its membership, all will concede. He labored for its advancement early and late, and year following year, for nearly half a century. He guarded it in its days of weakness, and proudly rejoiced in its maturing strength and growing influence.

If for naught else than his devotion to the American Institute, his memory should descend to latest generations, as one who dedicated his life to the advancement of his beloved calling and to the service of his fellow men.

Can it be possible that he will no more go in and out among us?—Then must precious memories be our heritage. He is not with us, but of a truth, "*His works do follow him.*"

His beautiful life and nobility of character, his devotion to the true and the good, his gentle sinking to rest at the close of day, suggests to us the Sun at its going down, leaving the sky all aglow with the reflection of its glory;—sure prophecy of a more glorious to-morrow.

To have known him and his great manly heart, was the privilege of a life;—he called me his friend, *and I loved him.*

ADDRESS OF JOHN L. COFFIN, M. D.,
BOSTON, MASS..

Character in its fullest development, permeated by an individuality rich in conscious strength and filled with love for its fellowman, always commands the respect and admiration of mankind, and therefore it is that we are gathered together *in memoriam*, in memory of a man and a physician. Of a man, who, sustained by an unfaltering trust in God, rounded out, to within a few months, the allotted span of man's life; of a physician who for forty-five years gave himself, body and soul, to the service of suffering humanity and to the cause he so thoroughly loved.

It is not within my province, even if it were within my ability, to try to form any just estimate of the character whom we honor tonight. Rightly and justly to do this is hardly possible at this time, for to fairly estimate the value and influence of a man's life upon the time in which he lives, that life should not be viewed at too short range. Like a beautiful picture or a fair landscape, it should be seen from a sufficient distance to merge any distracting details into one grand harmonious whole of beauty. We come together not to examine motives, to criticise actions, to measure successes, but to pay to the memory of our friend and co-worker a loving tribute of respect, of honor, of affection.

In behalf of the Massachusetts Homœopathic Medical Society, for which I speak, I cannot do better than to show the great debt we owe our honored associate, by a brief resumé of the work done by him for and amongst us.

On February 16th, 1841, six physicians, brave men, having the courage of their convictions, Drs. Samuel Gregg, Josiah Foster Flagg, Charles Wild, John P. Spooner, William Cutler and Luther Clark, having "faith in the future of the therapeutic law whose guidance they had adopted," formed a society known as the Massachusetts Homœopathic Fraternity. In 1851, ten years after its birth, it had thirty-three members, and the name was changed to the present one of the Massachusetts Homœopathic Medical Society. On May 17th, 1853, Dr. I. T. Talbot was elected a member. In the following September he was elected Assistant Secretary. December 13, he reported a case. January 10th, 1854, he was elected Secretary and Treasurer. The next March with four others, only one of whom survives him, he was appointed on a committee to select two or more drugs for proving by the Society. April 11th, 1855, he resigned the Secretaryship to go to Europe. On October 23d, 1855, he read a paper entitled "On the establishment of a public Hospital and Dispensary," in which he speaks of the progress towards the establishment of a Hospital, the length of time it *must* take to raise the funds and establish the same, and then showed that *meanwhile* something must be done by Homœopathy and that something should be done toward the establishment of a free Dispensary. He shows the time to be especially propitious. The objections he forestalls by answering them before they are made. He arouses the enthusiasm of the Society both by somewhat caustic criticisms of their existing lethargy and by promising undeniable success in the scheme and thereby a widespread knowledge of Homœopathy and its results among the every day people. Finally he concludes by presenting a plan perfected even to small details for the practical establishment and working of the Dispensary. Thus in less than three years after becoming a member of the Society, he presents this address, in which he shows thus early that remarkable sagacity and political acumen which enabled him to see the ripeness of an occasion and to take

advantage of it. It is almost superfluous to say that the Society appointed a committee of which he was chairman, with full powers to act in the matter of a Public Homœopathic Dispensary. January 15th, 1856, he was re-elected Secretary and Treasurer. In June, 1856, the Massachusetts Homœopathic Medical Society was incorporated under the laws of the state, Dr. Talbot's name appearing as among the charter members. He had then been a member three years and had missed but one meeting except during the few months he was abroad.

June 25th, 1856, on the first meeting of the incorporated Society, he was appointed chairman of the committee to draft by-laws, and also substitute orator for the ensuing year. In 1857 he was on the committee on *Materia Medica*. May 5th, 1857, he presented a paper on the "History and Uses of some new Surgical Instruments." In 1859 he was elected substitute orator, and in 1860 orator. From 1861 to 1866, inclusive, he was Recording Secretary of the Society. April 10th, 1861, he delivered the annual address on Homœopathy. October 8th, 1862, he read a most valuable paper on "Tracheotomy in Croup," with a report of five cases, in which he says, in reporting the first case, that it was the first successful case performed by the Trousseau method in this country.

I have thus minutely sketched the work done in this Society during the first ten years of his membership to show that in the very beginning of his professional career he showed remarkable aptitude and ability and willingness for constant, laborious, valuable work. Interesting as it would be to follow thus minutely his course throughout his whole society life, time forbids and I can only mention a few of the more salient features.

In 1866 he was elected Vice-President, and in 1867, President. In the presidential address of that year he made a most urgent appeal for the proving of drugs and the more thorough education of the young physician. In 1868, as chairman of the bureau of Surgery, he strongly advocated conservatism in Surgery and mentions Carbolic Acid as a new and valuable agent.

In 1871, in the report of a committee to present a memorial to the Governor concerning the refusal of the Surgeon-General, William J. Dale, to approve the appointment of Dr. Henry P. Shattuck, as medical director of the First Massachusetts Brigade, on account of his Homœopathic propensities, Dr. Talbot testified that the Surgeon-General told him that if he, Dr. Talbot, would "ignore Homœopathy—give it up entirely, he would approve of his appointment to any position in the army." It is needless to say that he was not appointed at that price.

In 1871 he was a member of the committee to draft resolutions of sympathy and solicit aid for professional brethren suffering from the Chicago fire.

At a special meeting, called February 15, 1872 to hear the report of the committee on legislation in reference to the action of the Massachusetts Medical Society in expelling those members believing in the Homœopathic law, he made a most stirring speech, the beginning of which I cannot refrain from quoting. He says: "It is not homœopathic physicians merely that are concerned, but it is the liberty of the whole medical profession, not the question whether one man cures one patient to my ten or ten to my one, but whether he has a right to cure at all." With remarkable penetration he foresaw that though nominally a blow aimed at some sixty physicians, it was in reality a thrust at the very liberty of the people.

On October 9, 1872, Dr. Talbot presented a report for the committee concerning the need of a medical college, to the effect that a Medical School in New England was demanded, "in which physicians may be educated in the principles and practice of Homœopathy as well as in the collateral branches of medical science." The report resulted in the appointment of a committee of five, including Dr. Talbot, with full powers. On April 9, 1873, Dr. Talbot for the committee reported that they had accepted the offer of Boston University to receive the college as one of its departments with the prospect of acquiring the property of the New England Female College for \$42,000 — \$30,000 of which had already been raised. On April 15, 1874, he reports that the college is an entire success thus far, both in the number and character of its students.

Let me ask you to stop for one moment, and realize what this means. In six months from the time the subject of the establishment of a medical college was definitely considered, a committee of five men made an alliance with an already powerful University, and raised three quarters of the money sufficient to secure the necessary property. One year from that time the college was equipped and a success. There were five men on that committee, but those who were in the midst of affairs in those stirring times know that the moving spirit which animated and directed and encouraged and upheld that committee and made this grand result possible was the spirit to whom we pay a loving tribute of honor tonight.

In similar vein could I speak did time permit, of his part in the establishment of the Massachusetts Homœopathic Hospital, the various Dispensaries and the Hospital for the Insane at Westboro. Among many other labors which could with interest be mentioned are resolutions regarding Homœopathy in the army and navy in 1884, the report of the committee on securing equal advantages for Homœopathic students in public institutions and his success as chairman of the committee to ask state aid for the Hospital.

I have thus far spoken principally of executive matters of which he was a part, but there are in the archives of the Society many valuable papers and essays on medical and surgical subjects, showing that

amidst the whirl and bustle of the busiest of lives, he still found time for study and research, of which he was ever ready and willing to give liberally for the benefit of his fellow practitioners.

I have thus briefly endeavored to outline his work in this Society, but believe me it is only an outline. Almost every page of its history for the past forty years teems with evidence of his labor, much of it of the character of drudgery. There may be others who have done equal work or been of equal service and value, but if so the deponent knoweth not the name thereof.

All honor to that brave fraternal band, who in the face of invective, of ridicule, of social and professional ostracism founded this Society, but following their noble work there was the need of a strong persistent, discerning, courageous soul to advise, to direct, to govern, to encourage. That soul joined the Society May 17, 1853, its labors ceased July 2nd, 1899.

Neither the cunning of the sculptor's chisel nor the marvellous skill of the painter's pencil could justly commemorate the memory of this remarkable man. There is but one worthy monument and that is the perpetuation of his own work, the proper maintenance and care and development and perfection of those institutions which were his especial pride, and the continued dissemination of that medical faith to which he untiringly and joyfully gave his whole life.

“ Servant of God, well done ! They serve God well,
Who serve his creatures; when the funeral bell
Tolls for the dead, there's nothing left of all
That decks the scutcheon and the velvet pall
Save this. The coronet is empty show :
The strength and loveliness are hid below ;
The shifting wealth to others hath accrued ;
And learning cheers not the grave's solitude :
What's done is what remains ! Ah, blessed they
Who leave completed tasks of love to stay
And answer mutely for them, being dead :
Life was not purposeless, though Life be fled.”

Digitized by Google

	Page.
DIFFERENTIAL Diagnosis between Appendicitis and Inflammatory Affections of R. Ovary and Tube. H. P. Perkins, M. D.	136
DRUGS. Suggestions Regarding the Proving and Re-Proving of, Walter Wesselhoeft, M. D.	101
ECTOPIC GESTATION. A Peculiar Case of, Charles W. Morse, M. D.	78
EXECUTIVE COMMITTEE. Officers and Committees Appointed by, EMERSON, N. W., M. D.	14
Ventro-Suspension and Ventro-Fixation,	194
FLOATING KIDNEY. G. Forrest Martin, M. D.	148
FOREIGN Bodies in the Eye. The Use of the X-Ray in Locating, Geo. H. Talbot, M. D.	179
FULLER, SOLOMON C., M. D.	
Award of Medal to, for Original Research,	18
FUND COMMITTEE. Report of,	19
GALL BLADDER, Good Health without a, F. A. Hodgdon, M. D.	172
GONORRHOEA. Clinical Suggestions. Orren B. Sanders, M. D.	215
HARE-LIP AND CLEFT PALATE. Double. Carl Crisand, M. D.	143
HARTMAN, W. LOUIS, M. D.	
The Importance of Correctly Diagnosing Injuries to the Head,	155
HAYWARD, J. W., M. D.	
The Surgical Treatment of Acute Inflammation of the Uterine Adnexa,	211
HODGDON, F. A., M. D.	
Cholera Infantum. Its Pathology and Treatment,	70
Good Health without a Gall Bladder,	172
HONORARY MEMBERS. List of,	230
ILIO-COLITIS. D. W. Van Der Burgh, M. D.	65
" " Treatment of. G. H. Wilkins, M. D.	67
INJURIES TO THE HEAD. The Importance of Correctly Diagnosing W. Louis Hartman, M. D.	155
IODINE. Some Clinical Experiences with. F. B. Percy, M. D.	88
JOHNSON, E. R., M. D.	
The Result of Septal Deformities upon the Upper Respiratory Tract,	187
KIDNEY. Floating. G. Forrest Martin, M. D.	148
KRAUSS, JAMES, M. D.	
Some Points on Diabetes,	57
MARTIN, G. FORREST, M. D.	
Floating Kidney,	148
MATERIA MEDICA as a Specialty. John J. Shaw, M. D.	99
MAY, GEO. E., M. D.	
Fracture of the Patella,	161
MEDAL Awarded to Solomon C. Fuller, M. D.	18
MEETING. Fifty-ninth Annual.	17
" " " Semi-Annual. First day's session,	88
" " " " " Second " "	117
" Special, July 5, 1899. Death of Dr. I. Tisdale Talbot,	87

INDEX.

257

	Page.
MEMBERS. Complete List of,	223
“ Corresponding. List of,	230
“ Deceased. Obituary Notices of.	
Cate, Shadrach M., M. D.	32
Hale, Edwin M., M. D.	43
Harris, John T., M. D.	31
Houghton, Henry A., M. D.	42
Hunter, Horatio M., M. D.	40
Mitchell, Joseph Sidney, M. D.	43
Rand, Nehemiah Wheeler, M. D.	37
Sanders, Orren S., M. D.	39
Smith, J. Heber, M. D.	38
“ Elected April 12, 1899,	18
“ “ Oct. 11, 1899,	117
MEMBERS HONORARY. List of,	230
MEMORIAL TO THE LATE DR. I. TISDALE TALBOT,	231
Addresses by	
Codman, Col. Charles R.	
Representing the Laity,	238
Coffin, John L., M. D.	
Representing the Massachusetts Homœopathic	
Medical Society,	250
Dudley, Pemberton, M. D.	
Representing the Profession at Large,	241
McClelland, J. H., M. D.	
Representing the American Institute of	
Homœopathy,	247
Richardson, Frank C., M. D.	
Introductory Address,	235
Warren, William F., LL.D.	
Representing Boston University,	235
Wesselhoeft, Conrad, M. D.	
Representing Boston University School of	
Medicine,	244
Order of Exercises,	232
MIDWIFERY, Practical Points in the Practice of,	
Geo. R. Southwick, M. D.	84
MOORE, J. Herbert, M. D.	
Oration : — “ Twentieth Century Homœopathy,”	119
MORSE, Charles W., M. D.	
A Peculiar Case of Ectopic Gestation,	78
NECROLOGIST. Report of,	31
NERVOUS HEADACHES. A Similimum for,	
Nelson M. Wood, M. D.	92
OCCIPITO-POSTERIOR PRESENTATIONS,	
John F. Worcester, M. D.	81
OFFICERS, List of, for 1899-1900,	5
“ Election of, April, 1899,	23

	Page.
ORATION:— "Twentieth Century Homœopathy,"	
J. Herbert Moore, M. D.	119
OSTEOMYELITIS. Charles H. Thomas, M. D.	169
PATELLA. Fracture of the. Geo. E. May, M. D.	161
PERCY, F. B., M. D.	
Some Clinical Experiences with Iodine,	88
PERKINS, H. P., M. D.	
The Differential Diagnosis between Appendicitis and Inflammatory Affections of the R. Ovary and Tube,	136
PRESIDENT'S ADDRESS. Herbert C. Clapp, M. D.	24
PROVING or Re-proving of Drugs. Suggestions on,	
Walter Wesselhoef, M. D.	101
REPORTS.	
Auditor's,	18
By-Laws Committee,	22
Committee on Clinical Medicine,	45
" " Dermatology, Syphilology and Genito-Urinary Diseases,	215
" " Diseases of Children,	65
" " Gynæcology,	194
" " Materia Medica,	88
" " Memorial to the late I. Tisdale Talbot, M. D.	231-8
" " Obstetrics,	78
" " Ophthalmology, Otology, Rhinology and Laryngology,	179
" " Surgery,	186
Election Committee,	23
Fund Committee,	19
Necrologist's,	31
Treasurer's,	17
SANDERS, ORREN B., M. D.	
Gonorrhœa. Clinical Suggestions,	215
SEPTAL DEFORMITIES. The Result of, upon the Upper Respiratory Tract. E. R. Johnson, M. D.	187
SHAW, JOHN J., M. D.	
Materia Medica as a Specialty,	99
SOUTHWICK, GEO. R., M. D.	
Practical Points in the Practice of Midwifery,	84
The Present Status of the Surgical Treatment of Salpingitis,	164
SQUINT. David W. Wells, M. D.	181
SURGICAL TREATMENT of Salpingitis. The Present Status of,	
Geo. R. Southwick, M. D.	164
SURGICAL TREATMENT of Acute Inflammation of the Uterine Adnexa. J. W. Hayward, M. D.	211
TALBOT, I. TISDALE, M. D.	
Memorial Service Oct. 30, 1899,	231
TALBOT, GEO. H., M. D.	
The Use of the X-Ray in Locating Foreign Bodies in the Eye	179

INDEX.

259

	Page.
THOMAS, CHARLES H., M. D.	
Osteomyelitis,	169
TREASURER'S REPORT,	17
TURNER, MAURICE W., M. D.	
The Use of Antidotes in Chronic Diseases,	48
UTERINE ADNEXA. The Surgical Treatment of Acute Inflammation of. J. W. Hayward, M. D.	211
VAN DENBERG, M. W., M. D.	
Letter from, on <i>Materia Medica</i> ,	98
VAN DER BURGH, D. W., M. D.	
Ilio-Colitis,	65
VENTRO-SUSPENSION and Ventro-Fixation.	
N. W. Emerson, M. D.	194
WELLS, DAVID W., M. D. Squint,	181
WARNER, FREDERICK A., M. D.	
Clinical Cases,	62
Necrologist's Report,	81
WESSELHOEFT, WALTER, M. D.	
Suggestions Regarding the Proving and Re-Proving of Drugs,	101
WILKINS, G. H., M. D.	
Treatment of Ilio-Colitis,	67
WORCESTER, JOHN F., M. D.	
Occipito-Posterior Presentations,	81
WOOD, NELSON M., M. D.	
A Simillimum for Nervous Headaches,	92
X-RAY in Locating Foreign Bodies in the Eye. The Use of the, Geo. H. Talbot, M. D.	179

